THE CANADIAN NURSE

PERIODICALS R.

LUME 54 • NUMBER 11
MONTREAL

Highlight for
OVEMBER 1958

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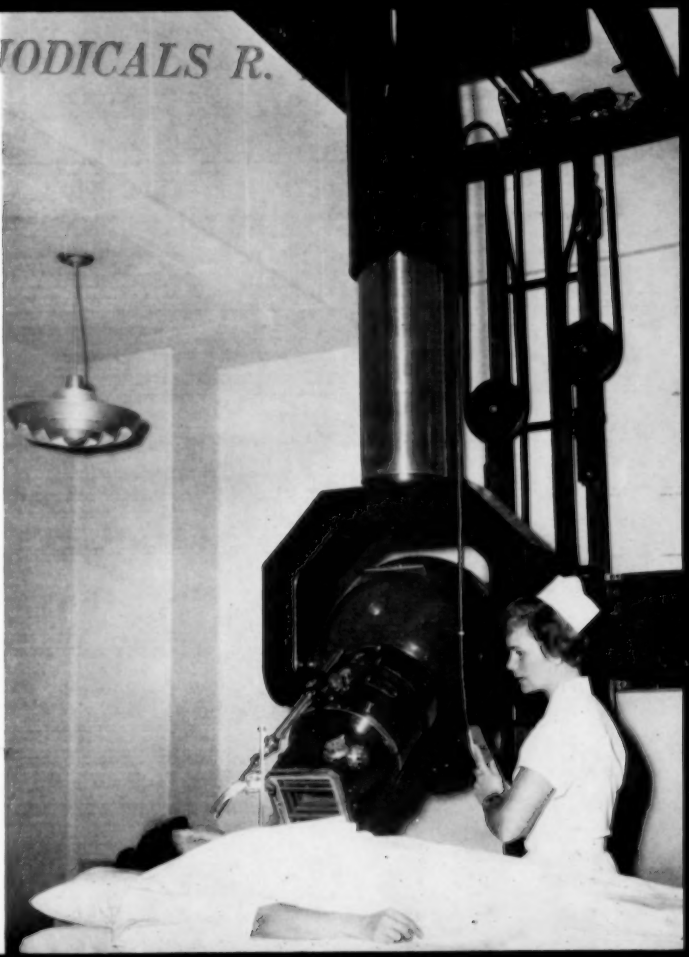

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CALLED BY: Mr. Neuman

MESSAGE: Called to say he's feeling much better but the intense itching rash has returned on his arms and legs. I recommended Calmitol and arranged an appointment for tomorrow morning.

A.T.

Thanks. Calmitol is one of the safest antipruritics we know and should relieve Mr. Neuman until I can see him.

S.L.

*Calmitol is the non-sensitizing antipruritic supplied as Ointment in 1½-oz. tubes and 1-lb. jars, and as Liquid, for more stubborn pruritus, in 2-oz. bottles by Thos. Leeming & Co., Inc., 286 St. Paul St., W., Montreal. *Write for samples.*

THE CANADIAN NURSE

L'Infirmière canadienne

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The views expressed in the various articles are the views of the authors and do not necessarily represent the policy or views of The Canadian Nurse *nor of the Canadian Nurses' Association.*

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Between Ourselves

A REMARKABLY COOPERATIVE author is our guest editor this month — **Lucy Dorothea Willis**, president of the Saskatchewan Registered Nurses' Association. It is our custom to draw up a proposed panel of guest editors before the beginning of each year and write to each at once extending the invitation to them to participate. Perhaps because November seemed so far off last January, the usual early letter to Miss Willis seems to have been overlooked. When we wrote her in July, she was on vacation. We were doubly grateful to her, therefore, when she met our deadline most graciously.

Born in Moose Jaw of Scottish parentage, Miss Willis graduated from Toronto Western Hospital in 1942. A year as junior instructor at the municipal hospital in Moose Jaw gave her the urge to take postgraduate training in teaching and supervision in schools of nursing. Armed with her certificate from the University of British Columbia, Miss Willis joined the staff of Saskatoon City Hospital where she served successively as head nurse, nursing arts instructor, clinical instructor, then educational and social director for the next six years. Through the University of Saskatchewan, she received a W. K. Kellogg fellowship which enabled her to spend the next two years in New York where she secured first her bachelor's then her master's degree. Returned to Saskatchewan, Miss Willis took an active part in the organization of the Centralized Teaching Program, serving as director of the unit at Regina College until she went to her present work on the faculty of the School of Nursing at Saskatchewan University.

* * *

The institutes and conferences sponsored by Dalhousie University School of Nursing for the nurses of the Maritime provinces are rapidly becoming the most eagerly anticipated professional events of each year. Open to representatives of every field of nursing in the area, attendance records are steadily increasing as nurses seize the opportunity to refresh their knowledge concerning specific conditions, to exchange views, to ask questions, to reap new ideas.

Last March, the institute was based on "Nursing Aspects in a Cancer Program." With cancer at the top of the list as a cause of death, interest was intense not only for professional reasons alone but from a personal point of view as well. In this issue we are sharing with you most of the papers that were given. For obvious reasons it is impossible to include all of the interesting discussions that took place though summaries of some of it will be found here. Perhaps this presentation will spark nurses' groups in other communities to organize similar studies.

Over and over again the importance of early diagnosis and immediate, adequate treatment of cancer was stressed. A panel discussion related to gynecological cancer, indicated this emphatically. The search begins in the office of the private physician where careful, conscientious history-taking and examination may bring to light menstrual irregularities, cervical or vulvar abnormalities, ovarian enlargement — all of which call for hospitalization and more thorough investigation. Surgery may be the answer and in the earlier stages the results may be most heartening. If not, treatment may be in the hands of radiotherapist. He must use his skilled good judgment in making sure that treatment is adequate but that normal tissue around the tumor is not destroyed.

Radical mastectomy, laryngectomy and similar types of extensive surgery for cancerous conditions do leave obvious changes in body contour or function. Anyone who has seen the surgery required to correct malignant conditions involving the mouth, face or neck would feel that there was justification in the use of the term "mutilating surgery." The panel discussion devoted to the rehabilitation of such patients following surgery provided a most interesting session. The doctor member of the panel figuratively rapped the knuckles of those who consider radical surgery mutilating. He reminded us that such surgery is done *to save life*. This underlined the main principle observed in electing patients for treatment since extensive surgery is not undertaken unless it is considered to be either *life-saving* or *life-prolonging*.

Many allied services may combine to help the patient following extreme surgery. For example, the woman who has undergone radical mastectomy is started on her way back to normal arm function by the physical therapist who begins an immediate regime of exercise and massage to prevent con-

(Continued on page 999)

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New Products

Edited by **DEAN F. N. HUGHES**

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HEMORAL

Manufacturer—Mowatt & Moore Ltd., Montreal.

Description—Each tablet: Cetaceum 175 mg., dioctylsodiumsulfosuccinate 15 mg.

Indications—For relief of pain, swelling and pruritus of hemorrhoids by emollient action and by softening stools.

Administration—2 tablets 3 times daily with a glass of water until relief obtained; ordinarily, one tablet daily for prevention.

INTRAZINE

Manufacturer—Intra Medical Products Ltd., Toronto.

Description—Tablets and ampoules of promazine HCl.

Indications—Acute state of agitation, such as encountered in drug addiction, alcoholism, and psychotic disturbances.

Administration—Due to the great difference in the degree of excitation treated, the dosage varies accordingly. 25 to 200 mg. may be administered 4 to 6 times during a 24 hour period, either orally or intramuscularly. Initial doses of 50 to 150 mg. may be administered intravenously in cases of excessive disturbance.

Not to be used in comatose patients or where hypotension is undesirable.

MIKEDIMIDE 0.5%

Manufacturer—Panray Corporation, N.Y. **Can. Dist.:** Winley-Morris Co., Montreal.

Description—Brand of Methetharimide or 3, 3-Methylethylglutarimide.

Indication—Barbiturate antagonist.

Administration—Intravenous injection administering 50 mg. over a three-minute period.

NEOHYDRIN

Manufacturer—Lakeside Laboratories (Canada) Ltd., Toronto.

Description—Each tablet contains: Neohydrin (chlormerodrin) 18.3 mg., thiamine HCl 0.667 mg., riboflavin 0.667 mg., nicotinamide 0.667 mg., calcium pantothenate 1.667 mg., ascorbic acid 25,000 mg.

Indications—As a diuretic in congestive heart failure, premenstrual tension, pregnancy edema and toxemia, migraine, recurring edema and ascites, cardiac asthma, hypertensive heart disease, dyspnea of cardiac origin, arteriosclerotic heart disease, fluid retention masked by obesity, patients averse to low-salt diet.

Administration—Maintenance of the edema-free state has been accomplished with as little as one or two tablets per day. When more intensive therapy is required, 1 or 2 tablets 3 times daily may be prescribed.

PLAQUENIL SULFATE

Manufacturer—Winthrop Laboratories of Canada Ltd., Windsor.

Description—Colorless crystalline solid, soluble in water to at least 20 per cent. Each tablet contains 200 mg.

Indications—For the treatment of acute or chronic rheumatoid arthritis with or without adjunctive therapy.

Administration—Antimalarial compounds are cumulative in action and will require several weeks to exert their beneficial therapeutic effects, whereas minor side effects may occur relatively early. There is great individual variation in patient response to these compounds, therefore, a rigid dosage schedule cannot be followed.

Initial dosage — From 400 to 600 mg., with a minimum of 200 mg. and a maximum of 1 Gm. daily.

In a small percentage of patients, troublesome side effects may require temporary reduction of the initial dosage. Later (usually from 5 to 10 days) the dose may gradually be increased to the optimum response level. If the side effects persist, substitution of aralen phosphate should be considered.

Maintenance dosage — At least from 4 to 12 weeks of therapy are required before beneficial effects can be properly evaluated. If a good response is obtained, the dosage is reduced by 50 per cent and continued at a usual maintenance level of from 200 to 400 mg. daily.

If medication is withdrawn a relapse, if it occurs, will usually be manifest within 3 to 12 months. Resumption of therapy, as outlined, will again be effective.

RAURYTOL

Manufacturer—Intra Medical Products Ltd., Toronto.

Description—Sugar-coated oval tablets containing: Total alkaloids of rauwolfia serpentina 2 mg., pentaerythritol tetranitrate 5 mg.

Indications—Symptomatic treatment of essential hypertension.

Administration—Orally 1 to 4 tablets per day, which may be increased after 7 days, until either the desired effects or side effects are obtained. Side effects consist of softening of stools or nasal congestion.

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Between Ourselves (Continued)

tracture and lymphedema; by her nurse who encourages her to wash her own face, brush her teeth, comb her hair using the affected arm. The occupational therapist tailors a work project that involves raising the affected arm and putting it through a useful range of motion. The speech therapist has, quite literally, given the laryngectomy patient a voice in his own affairs. Now, where possible, the post-laryngectomy patient is taught to develop a "pharyngeal voice" which requires much time and pains-taking effort. Occasionally the therapist encounters complete failure in teaching a patient to talk. Often this means that the individual has developed an emotional block that makes it difficult for him to accept his condition and rise above it.

Rehabilitation following radical surgery can be a long-term project. The patient may be ready to leave hospital long before rehabilitation is complete. The nurse in the community often is the only link between the hospital and the home. She must be provided with adequate resources so that she may function effectively.

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Manufacturer—Dome Chemicals Inc., **Can. Dist.:** Professional Sales Corporation, Montreal.

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Indications—For blemish concealment and treatment of acne vulgaris and related conditions.

Use—Apply immediately after washing 2 or 3 times daily.

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Manufacturer—Parke, Davis & Company, Toronto.

Description—An aqueous preparation of adenoviruses, types 3, 4 & 7, in approximately equal proportions grown in monkey kidney tissue cultures and inactivated with formaldehyde. Contains phemerol chloride 1:40,000 as a preservative. Also contains not more than 100 units of penicillin and not more than 100 micrograms of streptomycin per cc. used as bacteriostatic agents in the tissue culture of the virus.

Indications—For prophylaxis against certain acute respiratory and conjunctival infections caused by adenoviruses. The types used in the formula are those most commonly associated with respiratory disease caused by this group of viruses.

Administration—1.0 cc. given either intramuscularly or subcutaneously.

STEMETIL AMPOULES

Manufacturer—Poulenc Limited, Montreal.

Description—Ampoules of 2 ml. and 5 ml. containing 5 mg. of proclorperazine methanesulfonate per ml.

Indications—Nausea and vomiting, when an immediate effect is necessary or when oral and rectal routes are impracticable. Psychoses.

Administration—Nausea and vomiting: initial dose of 5 to 10 mg. (1 to 2 ml.) injected deep intramuscularly. This single dose may either stop nausea and vomiting or reduce its severity enough to permit tablet administration. If necessary, repeat the dose at intervals of 3 to 4 hours. The total daily dose should not exceed 40 mg.

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Administration—Suggested dose: Two tablets 3 or 4 times daily for moderate to moderately severe pain. One tablet, 3 or 4 times daily, may be sufficient for mild pain.

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Administration—Suggested dose: One suppository inserted twice daily for 6 days or as required.

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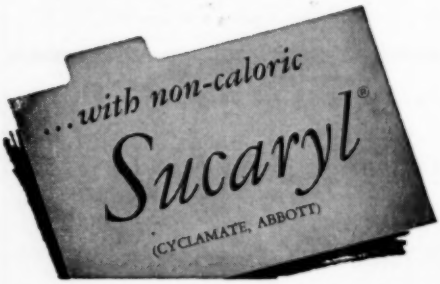

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A Part of the Deep Flow

WE HAVE ALL WATCHED with pleasure the sparkling flow of swiftly running water as it churns its way seaward. It calls us, through eye and ear, to stop and admire but even as we pause at its beckoning we know that much of this is only surface stirring, unharnessed and lost in its moment of display. Our economy depends on the deep, slower-flowing rivers to support its cargo-bearing vessels. It is around these unpretentious but useful channels that great cities grow, the work of the world is done, and the knowledge of the world is spread.

Often our modern way of living is compared to these effervescent and depthless streams. How easily we are attracted or distracted by superficial satisfactions, and seek amusement without effort, are present without becoming involved, or belong without contributing.

Is this also true of our professional life? Are the streams around which we build useful or merely attractive, abiding or transitory? Do we fool our co-workers and ourselves by the too ready use of the cliché, the current "word"? Do we pat ourselves on the back because superficial changes in old patterns mark us as "progressive"? Is the hunger of our inquisitiveness too easily satisfied by that which fills but does not nourish?

We need not look far for evidence. Any teacher who permits her students

LUCY D. WILLIS

to ask "why" knows how sadly we lack a scientific and logical basis for much of what we do in the sacred name of nursing arts. The practising nurse whose receptiveness is tuned in to her patients' problems knows that much of what she must do works at cross currents with the patients' real needs. No thinking pediatric nurse can truly say that the sick child, strange to hospital ways, is better off not seeing his mother in whom his basic security rests. Most of us know that telling the patient not to worry is worse than useless when he is concerned over whether he will die in a week, or a month, or a year. We prefer the appearance of tranquility to the turmoil of self-inspection. This, even though our professed aim as members of the health team, is to help individuals make full use of their physical and emotional resources in happy, effective living.

My window looks out on a busy crossing used by the blind from a residence half a block away. One day as I was idly watching the passers-by I noticed two pedestrians, one sighted the other not. The sighted woman, facing the traffic lights stood hesitant, fearful to step out. The blind man listened to the sounds around him, interpreted them and stepped off confidently toward the other side. There are none so blind as those who will not see! Let us open our eyes, and see what problems are before our profession as, in Canada, it steps out into its second half century of life.

Growth in the provinces is in step with our national growth. We in Saskatchewan are conscious of building for the future in a literal sense as we study blueprints for new provincial headquarters. I know we all felt we were building in another sense when we voted to have *The Canadian Nurse* subscriptions included in our annual fees. Enthusiasm for self-development, sparked on by the functional nature of our change in structure, should be fed by this monthly supply of food for thought. What other evidences of growth would we wish for?

One of the biggest thrills during the recent biennial meeting came from the closing scenes of the pageant. I refer to the portrayal of the Modern Nurse — knowledgeable about disease, proficient in nursing skills, and sensitive to the personal needs of the patient. Here was a beautiful expression of our aim in nursing. We have been bold enough to proclaim it in public, stripped of glamor and sentimentally but beautiful in its simplicity. Let us reach toward bringing all nursing to this level.

As we put together brick and mortar in our physical buildings may we also put together thought and action in professional development. Let us be more active in discussing nursing, in putting our ideas on paper, sharing them, exposing them to criticism, allowing them to be built upon, or swept away as the case may be. Let us have a professional life that is a challenge, and adventure, not just in organizational form, but in the real business of our profession — nursing itself.

Some, I know, might feel that an appropriate text for a message from Saskatchewan would be "the voice of him that crieth in the wilderness." However I have chosen as my closing words another message from the same prophet — speaking to the women of Jerusalem at a time of jeopardy for their nation "*Rise up, you women who are at ease, hear my voice; you complacent daughters, give ear to my speech*[1]." Nurses of Canada, show your mettle, prove your professional stature, be a part of the deep flow of the river of life.

1. Isaiah 32:9. R.S.V.

LUCY D. WILLIS
President
Saskatchewan Registered Nurses' Association

Last month, the *Nursing Journal of India* issued a special edition to celebrate the 50th anniversary of the national association. Nurses who have worked in India or Pakistan will be interested in the brief history of nursing in those countries which was written by Miss A. Wilkinson, for seven years the president of the Trained Nurses' Association of India.

—*I.C.N. Monthly News Letter*

The Cancer Problem

Norman H. Gosse, M.D.

Cancer is the second greatest killer of mankind. Nursing, being one of the great health services of our social order is interested, and would like to have clear guidance as to its place in relation to it. As in the case of the profession of medicine, your relationship to the subject of cancer is a double one. First and most obvious is your *professional relationship* — the place of nursing in the care of the cancer patient. In second place is your relationship to the subject as a *member of society*.

In every walk of life there are those whose sole interest in life is to be good only in particular and restricted fields in which they get their living — a good nurse, a good preacher, a good practitioner of medicine — but in whose case it can be said, "but he or she has no interest outside of that." Such persons are not our best citizens. Given two persons equally skilled in their calling, the one having broad interests will excel both in that calling and beyond it. She will make a greater contribution to society, and get much more out of life personally. Specifically, then, though cancer is but *one* of the many fields in which those associated with the healing arts may find interest, it is at the same time one in which, as members of society, we *should* be interested, because of its great sociological significance.

Measuring the Problem

The problem of cancer may be measured in several ways. One is in terms of *mortality*. If you would have it so measured, in terms of one province, then we are losing from cancer in Nova Scotia just about 1000 persons a year. If you ask what is the *incidence of cancer* is this province, one cannot be so precise in one's statement, for no scientific incidence study has been done here as yet. Generally speaking, however, it is accepted as being true, (though I suspect it is a bit on the low side) that there are *three living cancer cases* for everyone that dies. That would give us about 3000 cancer patients in this little province at any time.

I have said that I believe that the estimate is low. We have some evidence that this is so. In the Nova Scotia Tumor Clinic last year we saw 2713 cancer patients and there are many such patients who are not sent to the clinic. It might then be shown by a proper incidence study, that there are nearer 4000 than 3000 cancer cases in this province. This might be found to be higher than the relative figure for all Canada since the average age of the people of Nova Scotia is higher.

Accepting the Challenge

It has been the experience and practice of medicine from a long way back to regard disease as its enemy and so we speak of *fighting* disease. Not only was this so on the personal level as we used to think of it in fighting pneumonia, but on the broader public health level as well. In one case after another we have enjoyed victory. Smallpox, diphtheria and, we hope, poliomyelitis have been conquered. We have accepted cancer — so much more huge and difficult a problem — as another challenge. This challenge was really accepted long ago by our forefathers in medicine. Within their limitations, they made their contribution and passed the problem on to us. This generation has developed the subject further and is passing it on to the next as a subject of ever-increasing complexity.

Originally the war was limited to local skirmishes, with some bold surgeon occasionally cutting his way into prominence. There was, however, no special study of the subject, no organization of effort in treatment. Either anyone felt competent to treat

Dr. Gosse is the Director of the Nova Scotia Tumor Clinic, Victoria General Hospital, Halifax, N.S.

the disease, or there was widespread hopelessness and apathy about the whole subject. Quacks who knew nothing whatsoever of medicine flourished. Although they never did any good, there was a time when they probably did no more harm than the so-called qualified medicos of that day. The study of cancer was in a bad way.

With the advance of scientific medicine however, there came a realization that all was not well. Less scientific practices came under stricter discipline and knowledge. With the greater application of pathology, surgery advanced. With the application of biophysics to radiology, radiotherapy developed, separated from diagnostic radiology and became a specialty in its own right.

Realization that the enemy was powerful, widespread and deadly increased. With it came the greater urge to organize against the peril. Surgeons, radiotherapists and pathologists formed teams and within their limitations went forth to battle. But over and over, the resources of the enemy were found to be greater than theirs. Failure was a common experience. Thoughtful people in different fields of endeavor thought up new strategy, new means of attack, until in 1938 the concept of all-out war, in Canada at least, was publicized. The Canadian Society for the Control of Cancer came into being and the concept of total mobilization was born.

Behind this development and in connection with it was the realization that, in no aspect of our campaign against cancer did we have enough knowledge. The medical profession through its medical schools, postgraduate lectures and otherwise began the job of extending its education. In some of the great medical schools of the United States, separate departments under professors of Oncology, were set up and vast sums were spent on medical education in cancer.

However, ignorance of the condition among the public was found to be contributing greatly to the resources of the enemy. Men and women, either through lack of knowledge or from the apathy of hopelessness, were not seeking treatment until nothing could save them. Their instruction was undertaken on a national scale through every possible medium so that hope could be implanted and treatment undertaken before spread of the disease had far exceeded available means of control.

The effect was good, but we still fell far short of victory. Then began the renaissance of research — research that would show us the fundamental nature of cancer and that would eventually expose the chink in its armor that would be its undoing. Millions have now been poured into study in many projects. Great institutes have been established and men installed in them dedicated to lives of research. So far, important though it is, one cannot say that our present knowledge has saved anyone from a cancer death. Some day, we hope, it will save all mankind.

But should we sit back and wait for that? By no means! If it is to be all-out war, then that means complete mobilization of our resources.

Centres to which people with suspected cancer may be sent have been created. One such centre is located here in Halifax. It is a considerable distance from many places, but transportation costs for those with incomes of less than $300 a month are provided by the government of the province. At this centre, the Nova Scotia Tumor Clinic, we have divided the work into specialties covering regional anatomical groups — head and neck, breast, rectum, and so forth so that the groups of doctors concerned may concentrate on one kind of case only. By so doing they attain greater experience and greater proficiency in the treatment of cancer of these parts. Think of the experience available in a head and neck clinic averaging 30-35 patients in a day, or in a breast clinic seeing 20-25 patients in a day, in all the different kinds and stages of the disease!

Recently a statistical department was installed in the clinic. Preparations are underway for the processing of the first five-year results. This is the department that will show us our successes and our failures.

Hospital rules have been established respecting the way we believe patients should or should not be treated. For example, deep biopsies are not done unless the pathologist is there to do a quick section and unless we are

ready to proceed, without delay, with major surgery if it is indicated. There are many rules affecting the positive side, but there are also rules for what may be called the negative side. For example there is our refusal to offer radical surgery in certain cases because experience has shown that, in such cases, surgery would be harmful.

Cancer Education

We tend to talk of *5-year-survivals*. Often the results are disheartening, because of so many late comers — too late for much, if any, help — too late because they did not know the significance of a sign that belonged to cancer.

A chain is as strong as its weakest link. I have shown that *professional education* was weak — in some quarters it still is — but it has been very greatly strengthened. *Public education* is another link and a most important one. Where it is not well forged, disaster is sure to follow. It has been interesting to us, for example, to observe that from two of the most important counties in Nova Scotia a very high percentage of the cancer patients come with far advanced disease, and to realize that in both those counties, public cancer education has never been instituted. Even the city of Halifax, the seat of the provincial office of the Cancer Society, has produced far too many patients hopelessly incurable when first seen by a doctor.

The Cancer Society has seen this weakness of its coverage and has recently organized a unit of the Society for Halifax alone. This is not a new situation. Many Canadian cities are finding that smaller units are necessary in large cities if people are to be reached. The finest institution and the most capable professional personnel will fail if the patient comes to them robbed, by lapse of time, of all reasonable chance of cure.

What is the good of all our effort? Every bit of help that any one of us contributes to this cause benefits, not only the particular case immediately involved, but the whole subject. The excellent work done by our public health nurses in following up cases is not only to the benefit of the particular patient, but to the over-all picture of cancer as well. Let one department in this total mobilization against cancer fail and the over-all survival rate will not be as good.

As nurses, your interest in the subject and the degree to which you inform yourselves in it will affect your contribution to the education of the people of your community and the eventual control of cancer. Again, total war demands the most that we can give.

You may not all have opportunity at the community level since you serve in some other phase of nursing. The service of each one is equally important. Think, for example, of the depression so commonly observed in cancer patients and how very much can be done for such people in the right surroundings by understanding, cheerful people! How much gloom can be dispelled, how much happiness recaptured! And when the end is near, as it comes for so many of them, how important it is to remember that, though emaciation may have robbed the patient of all comeliness, we are still dealing with a human being whose mind may be as clear as our own.

In the fight to control cancer, in which obligation we are partners, let us use our wits wherever we may find opportunity. When it is clear, however, that in any given case control is impossible, when we have failed and treatment of the disease is without avail, let us then give peace to our wits and treat with our hearts!

An elderly correspondent has sent us some of the "health hints" she practises:

"If troubled with indigestion, eat with your eyes *shut* as much as possible.

"Do not cut toe nails, ingrowing nails, corns or callouses on the feet. Rub them down gradually with pumice stone. If this makes for some soreness, put on a pain killer when finished. File with the pumice every day or two until feet are in good condition; after that, care once a week should be enough.

"To reduce weight safely cut out sugars and *salt* as much as possible.

Early Detection and the Nurse

W. R. Carl Tupper, M.D.

While it is true that we have not discovered the cause of cancer and although we have no specific therapy for its treatment, we *have* learned how to increase the life span of many of those suffering from the disease. By improved methods of therapy — newer and better means of applying radiation, better techniques of surgery — we have increased our five-year survival rates in the past 10 years in practically all cancers:

In cancer of the cervix the cure rate has gone from 35 per cent to 45-50 per cent survival.

In cancer of the breast the cure rate has gone from 35 per cent to 40 per cent.

In cancer of the vulva from 35 per cent to as high 60 per cent.

In cancer of the large bowel from 35 per cent to 45-50 per cent.

Thus there has been approximately a 10 per cent increased survival rate over the past 10 years. With our present methods of treatment this is probably the best we can hope for. What then can we do to keep more of these patients alive for 5, 10, or 20 years?

Let us take cancer of the cervix as an example.

Survival Rates

Stage 0	—	100% cure
Stage I	—	70% "
Stage II	—	50% "
Stage III	—	16% "
Stage IV	—	0%

From this we can see that if we could treat our patients in the early stages most of them would be alive and well in five years. What actually happens is that most patients are beyond the early stage before they are seen — in fact only 20 out of 100 cases can be said to be early. There is a definite delay in the diagnosis of cancer of the cervix or in the patient coming for treatment.

The same story is true for most cancerous conditions. If diagnosed and treated early before spread to adjacent tissues or other parts of the body has taken place, the prognosis for survival is greatly increased. *Early detection* is the only hope of increasing the salvage rate.

Why then do we not get our patients early? There are two reasons — fear and ignorance. Fear of cancer is not new. We all fear it. This was brought home to me several years ago when a nurse in an American cancer clinic who had worked there for years and scolded many of the patients for delaying, discovered a lump in her own breast. Instead of going to a doctor immediately as she had taught others to do, she worried for two months before getting up courage to have her breast examined. Luckily, it was non-malignant.

This simply brings to our attention that fear of having cancer sometimes accounts for the delay that may mean the difference between life and death. This is where nurses can help greatly — by realizing themselves and telling others that even if it is cancer the condition can be cured if recognized early and treated. Many people still believe that *any* cancer is hopeless.

There are many who will say that we are scaring people to death, particularly in the cancer age group. There is, no doubt, some truth in this but it is our responsibility to guide the public so that fear will lead to strong and useful action rather than to panic. This will be accomplished when everyone has been told about the disease and what he or she can do to reduce its threat to life.

This leads us to the second cause of delay — ignorance. Ignorance of what the early signs of cancer are. How can we correct this? The answer is by education. Your cancer society has an educational program that endeavors to bring this information to the attention of everyone. We have seen the danger signals displayed on television, on posters or in the papers.

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We should know them by heart.

1. Any sore that does not heal.
2. A lump or thickening of the breast or elsewhere.
3. Unusual bleeding or discharge.
4. Any change in a wart or mole.
5. Persistent indigestion or difficulty in swallowing.
6. Persistent hoarseness or cough.
7. Any change in normal bowel habits.

These may not mean cancer but they *do* mean that the patient should see a doctor.

Can we discover cancer before it causes symptoms? Let me give you an example. The covering of the cervix and many other parts of the body exfoliate cells can be picked up on a slide and examined. A good cytologist can read the slide and separate normal from abnormal cells. It is thought that cancer of the cervix may start as an intra-epithelial lesion and may take as long as 3-4 years to develop into an invasive lesion causing symptoms. If the patient could be seen in this stage she could be offered a 100 per cent chance of survival. There is nothing to see on the cervix but it can be picked up by the smear. If every woman over 40 years of age would go for an examination once yearly, many of these lesions would be picked up. At the same time a thorough physical examination would bring to light lesions on any other part of her body.

Ignorance on the part of the patients is excusable. Ignorance on the part of nurses or doctors is not. We must educate ourselves so that we can advise the patient. The doctors are not blameless in this matter of early detection. We excuse ourselves by the old faithful "too busy." We, too, need education and an increased sense of responsibility. This is being done through postgraduate education.

What of the patient who has completed her treatment? Is she to be cast aside as either cured or doomed? These patients must be examined at regular intervals throughout their lives for evidence of recurrence. If such evidence is *detected early* much can be done either through further surgery or radiation. Let me demonstrate this.

The routine treatment for cancer of the cervix is radium and x-ray. By this means we can obtain a 45 per cent five-year cure. That means that 55 per cent either do not respond or respond for a while then have a recurrence. Several years ago in the Nova Scotia Tumor Clinic we became very interested in the group who did not respond or developed recurrences. We began watching for symptoms that would suggest that we were not getting results. From 1948-54 we found 50 cases. We decided to treat them again. By means of radical surgery we were able to save 25 per cent of these patients. By this I mean that they are alive today and without further evidence of disease.

It is clear, then, that when a patient with cervical cancer has a recurrence, it is not a hopeless situation as long as she is detected in the early stages of deterioration. Certain symptoms suggest recurrence:

1. Loss of weight.
2. The occurrence of a discharge of any kind particularly if it is foul smelling.
3. The appearance of a slough in the vault of the vagina.

These symptoms may not mean a recurrence but they certainly call for immediate examination. All too often patients come back with hopeless recurrences having had the above symptoms for many months. If they had been treated when their symptoms first reappeared, it is possible that a fair percentage of them could have been saved.

The same point can be made for cancer in any part of the body. For instance, a small lump is removed from the skin and it turns out to be a basal cell carcinoma. Any recurrence at the site should be reported immediately because it can be removed surgically again with good results, if this is done early.

If we are to increase our survival rate in cancer, the most potent weapon we have at hand is early detection. By education we can guide the public so that the fear of cancer will lead to strong and useful action rather than to panic. By education we can overcome the second cause of delay, which is ignorance of the early signs of cancer and ignorance of what can be done to cure cancer. In this we must all — doctor, nurse and patient — play a part.

Psychological Problems of the Cancer Patient

J. Fraser Nicholson, M.D.

The fear of knowledge of cancer is usually a severe threat to the individual. This is true not only in the minds of the ignorant, but even in the most erudite. Since cancer occurs in all kinds of people, the psychological response to it will mirror the habitual patterns of reaction of the individual. In one person the suspicion or knowledge of cancer will motivate him to seek early diagnosis and treatment. In another just the opposite will occur. It has been shown by numerous studies, that almost all patients, both those that delay treatment, and those that do not, "know" at some level of awareness that they are threatened with cancer. This "knowing" may only be an awareness of a change in well-being, and is not the kind of knowledge that is integrated and affects behavior.

Fear is an almost universal reaction to the threat of cancer. This may be fear of death, pain, mutilation, dependence or financial inadequacy. There may be fear of the loss of special tissues or organs that are psychologically significant to the patient, e.g., breast, uterus, genitalia, anus, face. Other fears include the thought of dirt, smells, uncleanliness, and the repellent aspects of the disease. Guilt is a very real concomitant of this fear. The onset of cancer is often viewed by the patient as the result of, or punishment for past sins, real or imagined.

The above emotions will move many people toward seeking diagnosis and treatment. The speed with which this takes place depends on the socio-economic level; the general and specific information on the subject of cancer; the relationship with the medical profession, especially with the personal physician; and the general stability of the personality.

Other individuals, in possession of the same set of facts may delay presenting themselves for treatment until pain, disfigurement or loss of function is so severe that it can no longer be ignored. "Delay" may be enhanced by *avoidance*, where the patient overlooks his lesion; by *suppression* where the lesion is noticed and dismissed from mind; or by *denial*, where the significance of the lesion is suspected, but is denied a place in everyday awareness.

Considerable research has gone into the study of factors at work in "delaying" patients. The following are some of the elements that are significant statistically:

Lower socio-economic group
Older age group
People without high school education
General emotional instability
Poor doctor-patient relationships

In all these groups, males delay more than females. In delaying groups generally there is a mistrust of the medical profession, hospitals, etc.

During the phase of active treatment of cancer, be it surgery or radiation, patients suffer a good deal of apprehension and anxiety. It is often not expressed, and may add to the patient's suffering. The same mechanisms of repression and denial are available to those that customarily use them. This may interfere with the total mobilization of the patient's forces to withstand the stress of operative or other treatments. Mild and even moderately severe depressive reactions are common in the post-treatment period. These are often characterized by ideas of worthlessness, a feeling that the patient is no longer useful. Reaction to mutilating surgery often results in a grossly distorted body image, in which the patient feels himself to be much more disfigured than is actually the case. These reactions often persist for months and even years, and result in much needless suffering and curtailment of activities.

The cancer patient in his terminal illness presents a great problem to relatives, nurses and doctors. Many patients, who would rather have an

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accurate appraisal of their situation are denied this by the almost universal feeling that such information would be harmful. While in many cases patients are obviously reluctant to be enlightened, many others would prefer knowledge that would enable them to put their affairs in order, and arrange what time is left in a way most meaningful to them. The question of who should tell the patient, how and how much to tell, will depend on many factors including family attitudes in general, the doctor-patient relationship, and the general stability of the patient. Most often the best arrangement would be for both the nearest relative and the doctor to discuss this with the sufferer. He can be reassured that with modern sedatives and tranquilizers, suffering can be reduced to a minimum and that, in most cases, his last days need not be a torment.

From the above it is obvious that there is much yet to be done in the field of cancer education. Better and more realistic attitudes to cancer, avoiding both the over-optimistic and the pessimistic, should be developed not only in the cancer patient, but in the public generally. Cancer education must stress *teaching* people the facts as we know them, not *preaching* and exhorting, which increases the unhealthy attitudes of delaying patients and undermines the confidence of many neurotic people who do not have cancer. Information must reach the lower socio-economic group, and especially the males. There is a good case for cancer education in grade school, industrial plants, and offices.

The recent deterioration in the public relations of hospitals and the medical profession has had the effect of making some of the uninformed groups suspicious, and resistant to this type of propaganda. The remedy, while not entirely in the hands of the nursing profession, can be helped by good nursing public relations, and a better nurse-patient relationship.

Discussion

A large portion of a nurse's satisfaction and pleasure in her work comes as a result of her relationship with her patients. So often she is the one who supplies the reassurance, the explanations and the words of comfort and encouragement. So often she is the recipient of the patient's fears, anxieties and problems.

It has been customary to attribute this relationship to the opportunities the nurse has to get to know her patient and to win his confidence. This fact is still true. However, it was somewhat startling to hear a physician give a different and more radical reason for the nurse's role as comforter, confidante and counsellor. Dr. Nicholson's blunt statement that doctor-patient relationships are frequently too poor, too much affected by distrust and suspicion, to allow for good human relationships met with open objection from an audience who undoubtedly remembered many instances to the contrary. Whatever our feelings in this regard, it would seem that, as nurses, one of our duties in helping to control the cancer problem will be to help the general public to overcome any feelings of doubt, distrust or suspicion of the medical profession and its services.

Dr. Nicholson had other suggestions, as well, directed particularly towards public education. To reach the "delaying" groups, other means must be found to get the information to them. He stressed the fact that members of the lower socio-economic group generally are not readers. Consequently information dispensed through the press does not reach them. More use should be made of radio and television and the information should *teach* and not *preach*, should avoid unnecessary alarm and fright. He felt that cancer education could begin very effectively in grades 8, 9 and 10 of our schools to reach that proportion of the school population for whom high school education might not be attained.

How often have you wondered about the advisability of telling or not telling a patient that he has cancer and of his possible prognosis? Even physicians disagree in this matter. It was interesting to hear the reaction of a group representing so many different areas of nursing. The majority decision — yes — *if* the emotional maturity of the patient warranted it. The responsibility for emotional assessment and actually telling the patient, may have left one or two questions in the minds of the audience. It was generally accepted that the doctor should be mainly responsible for the latter if relationships were satisfactory.

Educating the Nurse in Cancer Care

ETHEL M. CHANDLER

CONTRARY to general opinion it is frequently necessary to supplement basic nursing education in order to prepare nurses to work with the cancer patient. In the 13 years during which I have personally been associated with cancer nursing, we have discovered many areas in which the nurse has had little or no experience. This applies to the older graduate as well as the young practitioner.

Impossible as it may seem, many have never seen patients with colostomies, radical head and neck surgery, tracheotomies or brain surgery. Why does this situation exist? Perhaps it is because in the majority of our general hospitals in the United States these patients are required to employ private nurses. The students may, at some time during their surgical experience, see some of these cases and if fortunate, may be assigned to care for them. Some undergraduates may have contact with patients suffering from Hodgkins disease or leukemia during their medical experience, but unless the hospital is one in which there is a tumor service, these patients may be only an isolated experience. Because they are unfamiliar with this type of patient, nurses have a feeling of inadequacy and shy away from cancer nursing.

Others reject cancer nursing because of the depressing belief that all cancer patients die. This is no doubt brought about because of the terminal or advanced cases often seen on the wards. It is not always pleasant to work with such patients. There are odors and messy dressings. These people require a great deal of care and understanding to make them comfortable. But no patient is more entitled to this service than the cancer patient and as professional nurses, it is our responsibility to provide it.

The problem is how and where can cancer nursing be wedged into a curriculum already filled to capacity? How can nurses, now graduated, secure knowledge and practice in this area? In my country some schools have substituted cancer nursing for tuberculosis nursing. The United States Public Health Service introduced a plan for integration. As a result public health agencies and some hospitals have arranged to send teaching personnel to cancer nursing institutes. All of these efforts are helpful but as yet the great majority of nurses do not have access to cancer programs.

The New York State program conducted at Roswell Park Memorial Institute in Buffalo is, to the best of my knowledge, the most extensive program in operation today. Roswell Park is the New York State cancer research institute. Organized in 1898 as a laboratory, it is the oldest institution of its kind in the world. In the beginning the laboratory was supported by funds raised by public subscription and a small state grant. In 1915 it was taken over by the state and has expanded gradually from 32 beds to the present 304-bed, all-modern plant with over 1300 employees. The present building has a potential capacity of 500 beds.

A large Outpatient Department that handles an average 4500 new admissions and 45,000 revisits a year, acts as a screening area for all admissions to the Institute. Patients must be referred by their private physician or another clinic. They must be residents of the state of New York. They are supposed to have either a positive or possible diagnosis of a malignancy. There is no charge for services or treatment. Operating funds are supplied by the state. Research grants are made available to individual staff members by the American Cancer Society, drug companies, philanthropic foundations and industrial organizations. Basic research as well as patient care is carried on here.

Our cancer nursing care program started as an inservice project. Fifty-

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two lectures were planned and conducted twice each week for one hour each. The entire medical staff participated. Each service was responsible for at least two lectures. Medical sessions were followed by nursing care discussions or demonstrations. The program succeeded away beyond expectations.

From this beginning, the teaching of cancer nursing expanded to include our state public health nurses, the U.S. public health nurse consultants, hospital nurses, the University of Buffalo basic and graduate students, D'Youville College basic and graduate students, and two four-year basic schools. In 1957, the Department of Nursing was recognized as a division of the University of Buffalo School of Nursing. Six types of programs are in operation at the present time. There are:

1. A two-week orientation program for all new staff members.
2. An inservice program for staff nurses.
3. Two-week institutes for public health and hospital nurses.
4. Two-week practice programs for graduate students.
5. Four- and six-week courses for basic student nurses.
6. Two-week practice period as assistant head nurse for basic students from the University of Buffalo.

The orientation program for new staff nurses includes lectures by staff physicians, followed by nursing care lectures. Observation in the Outpatient Department, radiation therapy and central supply department and demonstration of procedures peculiar to cancer nursing are included. The inservice programs are planned and conducted by members of the nursing staff selected by popular vote each year. Suggestions for topics for discussion are requested from the staff. One meeting is held each month from September through June.

The two-week institutes for public health and hospital nurses consist of lectures, observation and demonstration of procedures.

The graduate student program is one of practice only. Students are assigned to a nursing unit for a one-week period so that in their two weeks with us they are actively engaged in the nursing care of selected patients. We have, however, reached the conclusion that practice without some previous classroom preparation does not produce the desired results.

The basic students receive lectures, observation and practice. Students are assigned to the nursing units for two-week periods. The affiliating period does not allow for experience in all areas. Nursing care studies are used to acquaint students with the areas in which they do not receive experience.

The assistant head nurse program is a recent addition and we are still exploring the value of this experience. The purpose is to acquaint the student with the principles of ward management and some of the problems of the head nurse. During the two weeks the student works closely with a head nurse and is assigned some of the minor responsibilities.

The nursing faculty consists of one educational director, one clinical instructor, 10 head nurses who teach their specialty, and a state consultant nurse from the Bureau of Cancer who attends the two-week institute for state personnel and the evaluation conference at the end of each student program. The chief of each major service plus the directors of the pathology, radiation therapy and radioisotopes departments participate in the program. The director of the Bureau of Cancer Control stresses the responsibility of the public health nurse in case finding.

Additional preparation is needed by the nurse working in the cancer field. As more funds are made available for cancer research, more nurses will be needed to staff the hospitals where this work will be carried on. We realize that we are fortunate in having a centre such as Roswell Park in which to prepare the nurses.

* * *

If the child who lives on in the grown person is chiefly a spoiled brat or a querulous, timid dependent — so that he constantly refuses to face up to the normal demands of adulthood — we can expect the individual's life to be marked by both inner and outer conflict.

— H. AND B. OVERSTREET

Gynecological Cancer — Diagnosis and Treatment

J. E. Stapleton, M.D.

The nursing of patients undergoing treatment for gynecological cancer must be carried out skillfully and with a great deal of understanding. The patient with cancer of the cervix has radium inserted into the uterus and vagina first. Then she has a three-week course of deep x-ray therapy followed by another radium insertion three weeks later.

While the radium is in position, the nurse can be subjected to radiation if she fails to realize that radiation cannot be perceived by the senses. Distance is the greatest protection that she can have against radiation. The nurse dealing with patients being treated with radium should carry out her duties efficiently and quickly and not pass the time of day with the patient while standing at the edge of the bed. Conversation can be conducted just as easily from a point at least six feet from the edge of the bed. Any nurse who is caring for a patient who contains a radioactive material will be provided with a film badge that is sensitive to radiation and indicates the amount of radiation to which she is exposed. This badge does not confer any immunity to radiation, but it allows the radiotherapist to determine the amount of radiation to which the wearer has been subjected.

Like any other sensitive measuring device, film badges must be treated with a reasonable amount of respect. They refuse to function after laundering and they record none of the radiation to which the nurse is exposed if they are not worn! It may be well at this stage to say a little bit about radiation in general. All of us are subjected to irradiation from the cosmic rays from outer space. This has been going on since the world began. The risk of genetic mutations is not a new hazard that has been introduced with treatment by radiotherapy. After years of experience, a dose of radiation has been worked out that has never been known to cause any damage even to people who have spent the whole of their lives subject to it.

To be on the safe side, the dose has recently been cut by one-third and the safe permissible amount now stands at 1300 milliroentgens in any quarter year. This is considerably less than the quantity received during some diagnostic x-ray examinations. Every effort should be made to see that a nurse is never put into a situation where she is likely to exceed this dose.

Following the first insertion of radium the patient is given three weeks of x-ray therapy. Good nursing at this stage may decide the ability of the radiotherapist to treat his patient successfully or not. Naturally, in trying to irradiate the parametrium, it is inevitable that loops of the bowel will be affected. This causes some people to suffer from anorexia, nausea and vomiting during the course of treatments. Every patient undergoing deep x-ray therapy should have a high protein diet. The nurse should encourage the patient to take the diet even if it means spending a few minutes with her at the beginning of each meal. Fifty milligram tablets of Gravol are usually prescribed a half-hour before meals and at bedtime for patients suffering from nausea or vomiting. It does seem that a certain amount of exercise during the day and the opportunity for the patient to spend some time in cheerful surroundings also helps to relieve the effect of the radiation.

Towards the end of the therapy the patient's skin is likely to become red. It should be impressed on her that she must not wash the treated areas for at least six weeks after the conclusion of her treatments. Iodine and adhesive strapping should not be applied to the areas for any reason. The irritation that is usually felt once the erythema becomes visible is best treated with baby powder. Often it is a great relief to the patient to spend some time each day with the areas completely uncovered. If blisters occur,

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and this is likely to happen in very obese patients, Tyroderm ointment should be applied three times a day. It is expected that skin reactions and the tendency to develop radiation sickness will disappear with the use of Cobalt units.

If patients are sensitive to penicillin, then plain Unibase should be applied. Many of the common creams and ointments make the skin reactions worse and this is particularly true of vaseline. The patient should receive douches of soda bicarbonate daily during treatments and frequently when she returns home. A vaginal dilator is often given to these women to prevent atresia of the vagina.

It is quite common for the patient to complain of some frequency and scalding on micturition toward the end of treatment. This can usually be mollified by drinking plenty of water. Diarrhea is common at this same time; it can often be avoided if the patient is not given raw green vegetables and only minimal helpings of cooked vegetables for six weeks.

Perhaps a word should be said about nursing patient who has received treatment with radioactive gold. When the gold is first instilled the patient contains a large amount of radioactive material. However as the half-life of radioactive gold is under three days, the amount of radioactivity in the patient quickly falls. Usually it is not necessary for her to be kept in a special room for more than six days.

When the patient first returns to her room after having gold instilled, she is turned a quarter turn every fifteen minutes for four hours and then every half-hour for a further four hours. After this time she is allowed to take up any position she chooses. For the first three days no visitors are allowed. Once again the nurse must carry out her duties as quickly as possible and yet there is no reason why everything essential should not be done. The amount of time that the nurse need necessarily spend beside the patient is surprisingly small. It is unlikely that, if she obeys instructions, she will receive a dose of radiation greater than the permissible one.

Finally one's attitude towards these patients must be, at all times, cheerful and optimistic. They have a serious disease but their chance of cure is good and they should be made to realize this. Any tendency of the patient towards moping should be dealt with cheerfully and quickly. It is here that the nurse can prove a staunch ally of the doctor. The duty of the nurse is a responsible one and she should never let sentiment override her good judgment.

Bill of Rights for Older Citizens

Dr. Morris Fishbein, former editor of the *Journal of the American Medical Association*, has listed what he considers to be seven fundamental rights of all those who come to the years past 60:

1. Every older person has the right to tender loving care.
2. Every older person has the right to the most that medicine can do to provide freedom from pain and suffering.
3. Every older person has the right to ask for some interest or occupation worthy of his attention.
4. Every older person has the right to food, fuel, clothing, and shelter sufficient to his needs.
5. Every older person has the right to find happiness and contentment in his declining years.
6. Every older person has the right to the most that can be done to help him die comfortably of old age rather than uncomfortably of disease, accident or disability.
7. Every older person is entitled to as much peace of mind and peace of soul as modern civilization can give.

A miserable driver — tired, raw-nerved, irritable — is just another "accident going some place to happen!"

— *Blue Print for Health*

To accomplish great things you need not be a genius; you need not be above other men, you must be *with* them.

—Montesquieu

Nursing the Cancer Patient

MARGARET FERGUSON

THE CANCER PATIENT presents two special problems to the gynecological nurse. Both of these can be quite difficult and trying to handle. First of all, there is the emotional problem of the woman with pelvic cancer who is in hospital for the first time undergoing treatment. Secondly, there is the terminal cancer patient who, either at home or in hospital, can try one's nursing abilities to the utmost.

EMOTIONAL PROBLEMS

The difficulties of the patient with pelvic cancer fall into four parts:

1. She either knows or suspects that she has cancer. Only wishful thinking can stop a woman who is getting radiation therapy from knowing this. Cancer is a dreaded disease. A great many people think that it is incurable. Perhaps they have heard of the terrible terminal suffering some women have undergone. They are, therefore, in terror of their disease in a way that one is not in terror of such a condition as gallstones or hyperthyroidism or a fibroid tumor.

2. Part of the treatment, even if it is only radium insertion, is operative and involves an anesthetic. In some cases, where there is vulvar, ovarian, or intrauterine cancer, a serious major operation is involved. The patient is afraid of the operation.

3. Operation or radiotherapy will completely disrupt the ovarian function. The woman will not menstruate again. She may go through the symptoms of the menopause at a very young age, 25-35. A great many women therefore worry about the future of their sexual function.

4. Treatment with radium and certain operations tend to cause shrinkage or shortening of the vagina. The discovery of this sometimes upsets the woman greatly.

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As a result, a special system of handling the female patient with cancer of the pelvic organ has had to be adopted. It is based on constant reassurance and building up the morale. How do we do this?

We believe it is better for the patient to know the truth. As it says in the Bible "Ye shall know the truth and truth shall make you free." Our feeling is that once the patient knows what she is up against she will tend to brace herself to meet it. More than that she is more easily persuaded to come back regularly for the next five years for checkups at the cancer clinic. Coming back to the clinic she meets other women who have come back free of recurrence for years. This in itself has an encouraging effect on her.

We tell her from the beginning what the treatment will be, how long it will last and what her chances are. We emphasize the great importance of coming back for regular examination and letting the clinic know the moment she notices anything unusual. On final discharge from treatment the patient is given the following instructions to jog her memory:

IMPORTANT

1. You should note the following carefully. Your life may depend on it.

2. Your next visit back will be on —. Be sure to keep this appointment on this date. If because of some other illness or emergency you cannot keep the appointment come on the next nearest Tuesday or Friday at 11:00 A.M.

3. If at any time you notice any of the following write to

The Gynecology Department,
5 West,
Victoria General Hospital

immediately.

(a) Discharge — yellow, brown or bloody.

(b) Loss of weight for which you cannot account, or loss of pep.

(c) Pain in low abdomen or legs.

(d) Swelling of the abdomen or legs.

All the nurses unite in trying to surround the cancer patient with the greatest possible reassurance. She is encouraged to go out the solarium where the other patients gather and where the television set is located. The television has been a godsend in this regard. Most of the patients are in for about a month the first time, and the hours drag — especially if they are only receiving deep x-ray therapy. For the short time that the set is turned on each day, television takes the patient out of the atmosphere of sickness, inescapable in any hospital. There is no question that television is one of our great aids in overcoming the emotional difficulties of the cancer case. We urge the patient to go out for a walk every day, if only around the hospital grounds. We encourage her to knit, crochet, sew or make dressings to help to pass the time.

If a major operation is necessary we explain its nature. The resident doctor is really responsible for this, but since the patient is often nervous when talking to a doctor, she will usually come to the nurse and ask for further explanation. So, in effect, it is a joint effort. We follow this policy even when an operation of such severity and mutilation as a Wertheim (complete hysterectomy) is to be done. We are convinced that, once the woman has agreed to accept a serious operation, it is better for her to know what it will entail.

We have noticed a phenomenon that has not yet been described in the textbooks. Following the Wertheim operation and other such extensive pelvic operations, the patient almost invariably goes into a state of depression on the fifth day. This occurs so regularly that we can almost count on it. Up to that time the patient may have seemed extremely well adjusted and she may have done well physically. The depression varies in severity with the individual. It always requires a great deal of psychotherapy of the supportive, encouraging and reassuring type to combat. We have tried various tranquilizing and sedative drugs without much effect one way or the other. We find that it is very helpful if a patient who has recovered well from the same operation talks to the depressed patient. Television also helps.

Usually this depression is over in a couple of weeks, but sometimes patients are still depressed when they leave for home. This is not the type of depression encountered in psychiatric conditions but the patient is certainly down in the dumps and tends to stay there unless she is cajoled out of it. It is our firm conviction that, if we can get the female cancer patient to face her tragedy and her future with all the emotional resources that she has, she will lead a happier and apparently a more useful life.

Terminal Care

Many people feel that when treatment has failed in a cancer case and the condition has recurred and become hopeless, little can be done except to control the pain. Actually the terminal case presents a real challenge. In the first place, if the patient is having increasingly severe pain and is likely to live for several months, a tractotomy can be done. This operation gives great relief, and in the majority of cases there is little disability from it. Occasionally, the bladder loses its tone and has to have an indwelling catheter. This requires changing every four or five days. Sometimes there is weakness of the legs. The relief from pain is almost magical.

When, for one reason or another, a tractotomy cannot be done, we are faced with three problems that require handling. Pain, fear of death, odor.

In the past, we have had to use morphia gr. ½ as frequently as every two hours. This tended to make the patient confused and disoriented and very often did not relieve the pain.

For the past year or so, we have been using the "Carcinoma Cocktail." The mixture, which contains a tranquilizer, paraldehyde, gin and tincture of opium, seems to relieve the pain, but does not leave the patient in a confused state. If the patient is being cared for at home, this preparation is much easier to give than a hypodermic injection, and it is easier for the family.

Odor presents yet another problem. In hospital we use an Ozium spray which is helpful but does not eliminate odor. In addition, incense is burned. We have used a deodorant tent similar to an oxygen tent that can be

placed over the bed. This tended to frighten the patient, and is used infrequently now.

The care of the patient with cancer involves much more than routine efforts towards cure or alleviation of symptoms. Discovery of the condition and the methods of treatment necessary often constitute a severe personal tragedy. Fear of the outcome, in some instances of impending death, produces severe mental and emotional stress. The nursing care devised for such patients must take into account all of these factors in order to produce the most effective results.

La Leucémie

BLANDINE Y. GOSSELIN, M.D.

LA LEUCÉMIE OU LEUCOSE, connue encore sous le nom de cancer du sang, est une entité morbide à évolution fatale, caractérisée par une prolifération anormale des leucocytes ou globules blancs et de leurs précurseurs dans les tissus de l'organisme, principalement dans le torrent sanguin. On trouve une certaine quantité de globules blancs adultes dans le sang d'un sujet normal mais survient un état pathologique comme par exemple, une infection, et le nombre des globules blancs augmente. Chez le leucémique, le nombre des leucocytes n'augmente pas nécessairement, bien qu'il puisse parfois atteindre des chiffres de 600,000 et même de 1,000,000 par millimètre cube dans certains cas. C'est l'immaturité des cellules de la lignée blanche qui aide surtout à poser un diagnostic. S'il y a apparition de cellules jeunes dans le sang alors que le nombre total de leucocytes n'est pas sensiblement augmenté, on parle alors de leucémie aleucémique. Les leucoses peuvent être aiguës ou chroniques et cette distinction repose non seulement sur la rapidité de l'évolution mais aussi sur la morphologie de la cellule leucémique qui présente beaucoup plus d'immaturité dans les formes aiguës que dans les formes chroniques.

On subdivise encore les leucoses selon le type de cellules qui prédominent dans le sang; si la cellule prédominante appartient à la lignée lymphocytaire, on est en présence d'une leucémie lymphoïde; si par contre, ce sont les cellules de la série granuleuse qui présentent des critères d'immaturité, on a affaire à une leucémie myéloïde; la leucémie monocytaire est le plus souvent aiguë et caractérisée par la présence dans le sang de cellules monocytaires d'allure très jeune.

Malgré tous les travaux poursuivis dans les différents centres de recherches médicales sur les leucémies, on n'a pas encore réussi à préciser l'étiologie de cette terrible maladie et on n'a pas encore découvert de médicaments qui puissent la guérir. L'arsénal thérapeutique actuellement à notre disposition contribue, avec la radiothérapie, à obtenir dans certains cas des rémissions plus ou moins longues et à rendre le patient plus confortable que s'il était laissé à lui-même.

La lignée sanguine blanche n'est pas la seule perturbée dans la leucémie; la lignée rouge qui produit les globules rouges et la lignée mégakaryocytaire responsable de la formation des plaquettes sanguines subissent aussi des modifications importantes qui expliquent l'anémie et les tendances à saigner de ces malades.

Si on ne peut guérir les leucémiques, on peut tout de même parfois leur être de quelque utilité, tantôt en leur apportant une rémission temporaire par une médication antileucémique, tantôt en corrigeant leur anémie par des transfusions, tantôt en essayant par des antibiotiques de prévenir les infections, car même si le nombre de leurs globules blancs est augmenté, ces leucocytes ne contribuent pas à combattre les microbes, car ce ne sont pas des globules de bonne qualité. Les stéroïdes

Le docteur Gosselin fait partie du personnel de l'Hôpital Notre-Dame, Montréal.

ont parfois une bonne action sur ces malades en diminuant les tendances à saigner, en améliorant leur appétit et surtout en leur donnant une sensation de bien-être. Enfin un bon nursing peut, par l'application de mesures hygiéniques, diététiques et psychologiques, créer une atmosphère propice au réconfort moral dont ces malades ont tant besoin. Toutes ces mesures ne reculent malheureusement pas l'échéance fatale mais offrent tout de même l'avantage de rendre moins pénibles les derniers mois de la vie de ces patients en leur permettant même, dans certains cas, de mener une vie relativement normale plus longtemps et qui sait? Peut-être trouverons-nous enfin dans l'intervalle un moyen de les guérir définitivement?

Nursing Care in Radiation Therapy

ETHEL M. CHANDLER

THE ROLE OF THE NURSE in our modern hospitals is becoming increasingly complex. It is no longer enough to be able to administer so-called routine nursing care or to assist in the treatment or operating room. The professional nurse of today must possess sufficient knowledge to give and supervise good nursing care, know when such services are needed and why they are needed. The nurse working with patients receiving radiotherapy must have additional knowledge. She must be thoroughly familiar with the types of radiation therapy used so that she can provide essential patient care and at the same time protect herself and others from unnecessary exposure to any form of radioactivity.

In April 1956, the National Committee on Radiation Protection recommended that a total permissible exposure level of 100 milliroentgens (mr) per week for total body radiation be accepted as the maximum rate of dosage for personnel working in radiation installations and that the yearly tolerance dose be specified as five roentgens. (A roentgen is the international unit of quantity of roentgen rays adopted by the Second International Congress of Radiology at Stockholm in 1928.) It is further recommended that whenever possible the amount of radiation to which a person is exposed during the entire work day, " . . . be measured by a suitable measuring device over a long enough period to be representative of average working conditions." Film badges similar to the intra-oral dental x-ray film are worn by our nurses and all other personnel working with any type of radiation.

Three types of radiotherapy are administered in the care of the cancer patient. They are: x-ray, radium, and radioactive isotopes. The reaction following therapy is similar in all types of radiation. The degree of severity depends not so much on dosage as upon the area of skin or mucosa irradiated and upon the amount of tissue involved. It must be understood by the physician, the nurse and the patient that the treatment usually produces a fairly severe local reaction. The resulting skin erythema looks very much like a severe sunburn and, to the patient, feels like one. To call this planned reaction a "radium burn" or an "x-ray burn" is an error since it at once suggests carelessness in treatment. The reaction produced in the skin and mucous membrane is referred to correctly as "radio-epithelitis."

Patients undergoing radiation therapy fear the agent as well as the disease. The fact that nurses, physicians and technicians must protect themselves from over-exposure to all forms of radiation isolates the patient during treatment. Therefore, an explanation must be given to him as to why the

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personnel must limit the time spent with him although it is not dangerous for him to receive a carefully planned and regulated exposure. Nurses can promote understanding and break down prejudice by supplying information and reassurance regarding the value of radiotherapy.

X-ray Therapy

> . . . The passage of high voltage current through a glass-walled vacuum tube produces what is called x-ray and with the exception of the wave length is similar to the gamma rays of radium.

The apparatus used for x-ray therapy varies in power from the small 50 kilowatt machines for superficial treatment up to the machines which deliver one to two million kilowatts for treatment of deep seated growths. The patient is often concerned with the size of the x-ray machine and the idea of being left alone in the room while receiving treatment. To relieve these fears, the physician, nurse or technician must explain that there in an intercommunication system between the therapy room and the technician operating the machine. It is helpful for the patient to receive an explanation of the need for precise positioning and why he must maintain it. He should be told of the various sounds that he will hear when the x-ray machine is put into operation and while it is operating. If at all possible, the patient should be placed so that he can see the operator through the lead glass window and know that he is under constant observation.

The nurse must be aware that radiation therapy sometimes results in a systemic reaction that manifests itself in the form of nausea, emesis and loss of appetite. Other symptoms may be headache, mental depression and general lassitude. With a systemic reaction, medications such as pyridoxine (vitamin B6, 1 cc., intramuscularly or intravenously) or dramamine 50 mg. are helpful in preventing nausea and loss of appetite. Occasionally the physician may prescribe a sedative such as phenobarbital. If vomiting persists, it may be necessary to give intravenous fluids because the dehydration can prolong the nausea. It is most important that these patients be encouraged to eat because a good nutritional state helps them to tolerate the reaction produced by radiation therapy.

The stages of x-ray reaction often follow a pattern. On the 10th day of treatment the skin may present a reddened, moist appearance. At the beginning of the fourth week, a deep plum color appears and the skin may develop a dry, inelastic quality. By the end of the fifth week, healing begins and is usually complete a month later. Usually the patient is at home when these later symptoms occur so that it is important for him to know what to expect. The private physician and the public health nurse must also be aware that this erythema is a normal occurrence.

With the skin reaction, pruritus is one of the chief complaints. Application of a simple starch powder (corn starch) will help make the patient more comfortable. In a more severe reaction, the possibility of infection can be prevented by the use of antibiotic ointments and with vesication an ointment may be applied. Plain lanolin and gentian violet, one or two per cent, have been used to advantage. A high protein diet with plenty of fresh fruits and vegetables will aid in the healing process.

At the completion of x-ray therapy, even after skin reaction has subsided, the patient must be cautioned to avoid further irritation to the treated areas. This means protection from extreme heat, cold and sunshine. Also, friction from clothing should be avoided. The treated skin, because of its sensitivity, is much more susceptible to damage than normal skin.

Radium Therapy

Unlike x-ray therapy where no precautions are necessary in the nursing care of the patient, the nurses caring for the patients receiving radium treatments, must be taught to protect themselves while treatment is in progress. Other persons such as housekeeping and laboratory personnel must also be made aware of this need. The years 1900-15 mark the period when radium was used with little or no protection. In 1915, the first definite

recommendations for the protection of workers were made by the Roentgen Society of Great Britain.

The recommendations were based on distance, filtration and length of exposure to radiation sources. These suggestions made in 1915, formed the basis for the radiological recommendations adopted at the Fifth International Protection Committe meeting held in Chicago in September, 1937. To eliminate possible over-exposure of the worker, a safety program should be instituted wherever radiation therapy is employed. This program should govern the monitoring of radiation exposure and the precautions involved in eliminating such exposure. In the protection of nursing personnel, the recommendations of the Fifth International Committee should be utilized.

Radium is commonly applied in needles, plaques and applicators. It has been found most beneficial in the treatment of patients with cervical cancer. Since the nurse usually assists with the insertion and removal of the radium appliance and cares for the patient during treatment, she must observe radiological precautions. As there is no immediate visible effect of injury or damage, it is very difficult at times to impress upon the nurse and other ward personnel the need for self-protection. Unless constantly reminded, they tend to become careless.

Radium applicators are delivered from the laboratory in thick lead-lined containers. They must remain in these containers until used. The container may be mounted on a low, dolly-type push car, the handle of which is sufficiently long to provide distance between the container and the worker. The receptacles placed on the ward and in the clinics for use when radium is removed may be equipped with a container of zephiran chloride, 1:1000, placed inside the lead-lined cylinder. The cart is taken to the bedside and the nurse places the radium applicator in the solution, immediately upon its removal from the patient. The zephiran chloride acts as a cleaning agent until the applicator is dismantled by the radium technicians.

When handling radium it must be held as far away from the body as possible. Special long handled forceps should be provided for this purpose. Sinks and chambers where radium applicators are cleaned must be equipped with lead shields. The nurse should have another member of the nursing staff present when she removes an applicator. This facilitates the procedure and provides a witness if there are needles and packing which must be counted. Both nurses sign the radium treatment sheet indicating time of removal, type and number of applicators and number of pieces of packing. To alert all personnel, a large radium sign should be posted on the patient's bed and a smaller one at the entrance to the room. The bed sign may be a bright red; the door sign, a brilliant yellow with red markings, the standard radiation hazard insignia.

The nursing care of the patient should be completed as rapidly as possible to allow for a minimum of exposure. The patient should be required to perform as much of his of her own care as possible. Because patient morale is important, the nurse must be able to work quickly and effectively without giving the patient the feeling of being rushed. When not actively engaged in the care of the patient, the nurse should maintain a distance of six feet between herself and the patient. Visitors must be cautioned to keep away from the bedside.

In order to record the amount of exposure received, a monitoring device such as a film badge should be worn by each nurse. In the care of patients with cancer of the cervix and bladder, wrist badges should be provided for use when a catheterization of the urinary bladder is performed. All badges must remain on the ward at the end of the day. New badges are issued each week and the used ones returned to the factory for development and evaluation. If an over-exposure (100 milliroentgens) is discovered, the person involved must be removed from all contacts with radiation therapy for a period of 13 weeks.

Patients receiving radium therapy are not allowed bathroom privileges because of the danger of displacing the applicator. Bedpans must be examined routinely for the presence of needles or applicators.

In institutions where a large num-

ber of patients are treated with radium, special precautions are necessary in the placement of beds. Nurses should be rotated routinely and practices checked regularly by a member of the radiological safety staff. Frequent routine blood counts are required by some institutions to determine the hemoglobin level of workers engaged in radium work. No pregnant nurse should be allowed to work in an area where radiation therapy is used.

Radioactive Isotopes

Approximately 70 of the known radioactive isotopes are now used for clinical purposes. Of the 70, radioactive iodine, phosphorus in the form of chromic phosphate and radioactive gold are the three most commonly used. The increased use of these substances for diagnosis and treatment has caused the nursing profession to pause and consider the problems involved in their use.

Clinically, radioactive isotopes are used for two distinct purposes. The tracer dose is for diagnostic purposes. As the dose administered is usually quite small, the amount of radiation emitted is negligible and does not necessitate special precautions. With the therapeutic dose the nurse must know the type of radioactive isotope used, the amount given, the route of administration, the forms of ionizing radiation emitted and the means of elimination. Isotope therapy is usually not considered dangerous for nurses and other hospital personnel *if* the precautions and regulations are understood and observed. The nurses caring for these patients must be thoroughly instructed.

Radioactive Iodine: The radioisotope of iodine commonly used is I-131. It emits both beta and gamma rays and has a half life of 8.14 days. According to accumulated evidence this isotope is best utilized in the treatment of certain forms of metastatic thyroid cancers. Excretion of radioactive iodine takes place chiefly through the kidneys. About 60-70 per cent is eliminated in this manner by healthy humans within 48 hours at a rate of about 5-9 per cent per hour of the circulating radio-iodine. The oral administration of I-131 indicates the need for caution in the disposition of sputum or vomitus. Small amounts may also be eliminated in perspiration. This makes a patient treated with the substance a potential radiation hazard. However, the patient need not present a hazard if all precautions are observed.

One technique for the nursing care of patients receiving radioactive iodine is as follows:

1. Patient is placed in a private isolation room with a "radiation hazard" sign posted on the door.
2. No visitors are permitted in the room. The nurse remains only long enough to complete essential nursing care.
3. An isolation gown, rubber gloves and heavy rubbers over the shoes prevent clothing and feet from becoming contaminated. A film badge is worn under the isolation gown, attached to the nurse's uniform. to prevent contamination of the badge.
4. An indwelling catheter is inserted into the urinary bladder before treatment. The catheter is clamped shut and released every two hours following the administration of the radioactive iodine. As the urine is the main source of contamination, it is important that not one drop be allowed to spill on the floor, in the bed or any place except into the lead encased gallon jug provided for that purpose.
5. A quantitative specimen of urine is collected every 24 hours for the first 48 hours and sent to the Radioisotope Department for assaying. This is necessary to determine the amount of I-131 excreted and to decide when the patient may be released from isolation. If there is spillage during the isolation period, the Radioisotope Department is notified immediately.
6. The floor is monitored with a survey instrument. The contaminated area is scrubbed thoroughly with soap and water by a member of the housekeeping personnel, instructed in the technique by the radiological safety officer.
7. After scrubbing, the floor is again monitored. If the reading is over six milliroentgens, is must be rescrubbed until the reading is well below the permissible level.
8. All linen, dishes and equipment must be handled separately.
9. Special linen tagged with red markings is reserved for these patients.

10. The soiled linen is placed in a galvanized can stored in the patient's room. It must be monitored for safety before being sent to the laundry where it is processed in an individual washer.

11. Paper wipes are placed in a paper bag and burned as necessary in the radiological incinerator.

12. If the patient becomes nauseated and has emesis, the radiological safety officer must be notified immediately.

13. At the end of 48 hours, the urine is no longer saved for quantitative analysis.

14. The room is monitored for radioactivity and the patient released from isolation upon orders of the radioisotope physician.

15. After discharge of the patient, housekeeping personnel scrub the furniture and floor with soap and water and the room is aired for 24 hours.

16. Monitoring must establish that the radiation level is below six milliroentgens before the room is ready for occupancy by another patient.

Radioactive Gold: Originally AU-198 was suggested for the treatment of leukemia, but because of its affinity to the reticulo-endothelial system its use has been extended to the treatment of pleural effusion and intraperitoneal tumors. It has been proven that administration in a colloidal form into a body cavity can cause considerable reduction in fluid formation and may eliminate drainage for some time. Radioactive gold has a half-life of 217 days and is produced by the bombardment of stable gold with neutrons. It emits both beta and gamma rays. As a gamma ray emitter, it involves certain radiation hazards. Protection from the rays of AU-198 is provided by distance and the filtering of the rays by the patient's body. Special techniques are necessary for the disposal of contaminated dressings or linen. Nursing care technique might be as follows:

1. Isolation technique is not necessary.

2. Nursing personnel must wear film badges and limit time spent with the patient.

3. As the only area of contamination is through the point of insertion, the patient's dressing is checked frequently for a purple stain. Radioisotope Department is notified promptly if this occurs.

4. Contaminated linen is placed in a special galvanized container and the stained dressing in a similar can. The linen is given special laundry processing after being monitored. Dressings are burned.

5. The nurse is cautioned to wear rubber gloves when handling contaminated linen and dressings.

6. To insure even distribution of the AU-198 after injection, the patient is turned every 15 minutes for two hours — first on his left side, then on to his abdomen, his right side and, finally, his back. This is carried out for two complete rotations.

7. Patient is usually discharge five or six days after treatment.

Cobalt 60

Teletherapy with Radiocobalt (Co 60): Radioactive isotopes can also be used in shielded units as a source of radiation similar to that of radium and high voltage x-ray. Cobalt 60 is obtained by bombarding ordinary cobalt with neutrons in a reactor. The advantage of the artificially produced isotopes seems to be in the flexibility of their use and in the quality of their radiation. Price-wise they are also much cheaper than radium or x-ray therapy units.

Although Co 60 emits gamma rays, the actual protection requirements depend upon the type and dosage of the source and the weekly irradiation hours. Safety precautions that should be utilized include the wearing of monitoring devices by personnel, electrical interlocks, warning bells, or lights attached to all doors leading to treatment room or other hazardous areas. The patient is unattended during the time the treatment is in progress. As in x-ray therapy, there is no danger to the nurse or other hospital personnel on the nursing unit.

Postmortem Care

Should a patient expire shortly after administration of a radioactive isotope, a radiation hazard tag is attached to the body to indicate the type of isotope given. This is to assure adequate protection for the pathologist and the mortician. A radiotherapist and pathologist should discuss precautions with the

mortician's organization so that they understand how to handle the body of a person who has had recent isotope therapy.

Summary

It is the responsibility of any hospital or institution employing the use of any type of radiation therapy to establish safety rules for its personnel. Physicians, nurses, scientists, technicians, housekeeping maids, maintenance and laundry personnel, must be thoroughly instructed in the type of radiation used and must know when this radiation presents a personal hazard. They must also be made to understand that if the safety precautions are scrupulously observed, there is no danger in working with the patients or in the areas where radiation is used. As a further protection, personnel in constant contact with any type of radiation, particularly radium and the radioactive isotopes, must be supplied with some type of monitoring device that is worn on their persons during working hours.

Urine, emesis and sputum from a patient treated with I-131 cannot be disposed of in a common sewage system until a monitoring device indicates that the amount of radioactivity is less than six milliroentgens. Bed linen and hospital gowns must remain in a galvanized storage can until the six milliroentgen level is established before being sent to the laundry. Dressings must also be stored in a similar container and then burned. Tracer doses of the radioactive isotopes usually pose no problem since the amount given is so small. Patients receiving x-ray or cobalt 60 therapy present no problem since only repeated exposure to the direct rays is harmful. There is no danger in working with patients receiving therapy if you know and observe the safety rules.

In the Good Old Days

(*The Canadian Nurse* — November, 1918)

The "good nurse" of today, especially in the newer fields of nursing, must be ready not only to follow orders, but to make her own plans and carry them out; not only to take good care of sick people, but to teach them how to prevent illness; not only to serve the individual, but to serve the public and the community.

* * *

As rapidly as possible we must prepare more nurses for teaching work. We need the brightest women we can find — those with good educational background, sound professional training, and with that enthusiasm, vigor and personality which are necessary to successful teaching.

* * *

The eyes of every newborn child should be treated to prevent ophthalmia neonatorum. This is an attempt to prevent blindness which follows infection of the eyes from venereal discharges at the time of birth. Nearly a quarter of the cases in one school for the blind was due to this cause. Ontario has enacted legislation covering this subject. Every province in the Dominion should do likewise.

* * *

In the weekly bulletin of the New York City Department of Health, bottled milk was quoted at 14 cents a quart, porterhouse steak at 35 cents a pound and eggs at 60 cent a dozen.

* * *

A new military hospital with accommodation for 1000 patients was planned for a site in Toronto. Estimated construction costs were $300,000.

* * *

At the convention of the American Surgical Association a most interesting discussion took place on the recent discovery of so-called bottled blood, known to the medical profession as citrate of blood, which had been used extensively and successfully on the battlefields.

If some people do not seem to be polished, it may be because you are rubbing them the wrong way. — *Hospitals*

There is some consolation in the fact that even though dreams don't come true, neither do nightmares. —*Builders*

The Public Health Nurse in the Cancer Program

DOROTHY FOWLER

AS NURSES, we realize how much has been accomplished in cancer research and the care of the cancer patient. We realize, too, how much more there is to be done in this field of medicine. We, who are public health nurses, feel at times inadequate to the task. But we know that the nursing world today holds no room for inadequate performance. We must look to the resources at hand, seek others when necessary and face up to our obligations.

In discussing the home nursing care of the cancer patient, it might be wise to start with the patient going into hospital and deal later with the patient after he returns home.

"Hospital" is often a fear-producing world. Coupled with "surgery," it can mean sheer panic for both patient and family. The public health nurse could do much to alleviate the fear of hospitalization for all concerned. A few words of explanation in relation to admitting and hospital routine can mean the difference between an apprehensive and a confident patient. The family, too, could be encouraged to adopt an understanding, optimistic attitude. This implies that the public health nurse would know from the beginning of the patient's impending admission.

The public health nurse can prepare the family for the return of the patient to the home. She may advise in the selection of a room that will be comfortable for the patient and convenient for the family in caring for him. She decides if the care of the patient will necessitate a hospital bed and plans the equipment that will be needed for treatment. She finds out where these necessities can be obtained and at what financial obligation, if any, to the family. Since this preparation can be done before the patient comes home, much confusion can be avoided.

Miss Fowler is a regional supervisor of the Victorian Order of Nurses for Canada.

The patient must be prepared for his homecoming before his discharge from hospital. He may be taught and encouraged to give his own treatments. Sometimes it is advisable to have the nurse who will be visiting the patient in the home, come to the hospital and observe the treatments. By so doing she may be able to assist the patient more effectively.

It must be remembered that the immediate period of convalescence is often one of depression and despair. A patient who has had a colostomy, finds it difficult to adjust to the loss of normal bowel function. He needs encouragement and reassurance that others have mastered this handicap. The amputee and those with other deformities often react with a deep resentment. Those dealing with such patients should teach them to overcome the disability as much as possible.

The nurse should know the community resources to which she can refer patients for occupational therapy, vocational rehabilitation and any other assistance relative to the patient's welfare. Helping the patient to help himself is all-important. There is nothing more humiliating to any patient than to be completely dependent on someone else for his personal needs. The task of rehabilitation may be an arduous one and often discouraging. It can be accomplished through patience, tact and continued effort on the part of the nurse, the family and the patient.

We have been thinking mainly in terms of the patient who is going to make at least a partial recovery, based on the location and development of the cancer. What of the patient who is facing the terminal stages of the disease? His comfort and the peace of mind of the family can depend on the attitude and tactfulness of the nurse and the quality of nursing care. As long as is possible, the patient should be encouraged to remain ambulatory. The administration of drugs and sedatives, as ordered by the doctor, should be very carefully interpreted

to the family. New symptoms that may appear very frequently in these latter months should not be passed over lightly. Attention must be given to them and, when possible, any discomfort alleviated. When the time comes for heavier sedation, the observant nurse can be of considerable assistance to the doctor in estimating the patient's response to the drugs. More frequent visits may be necessary. The spacing of these visits is important, too, so that the patient may have attention when he most needs it. Nothing should be overlooked in the effort to obtain the maximum amount of comfort for the patient.

The public health nurse then has definite obligations to the cancer patient and to his family:

1. To help the patient and family adjust to cancer as an illness.
2. To interpret physician's orders.
3. To explain and demonstrate procedures in relation to treatment as ordered by the physician.
4. To teach a member of the family the care of the patient between the nurse's visits.
5. To encourage independence in care and treatment, whenever possible.
6. To motivate the patient to report any new signs or symptoms promptly to his physician.
7. To give meticulous nursing care.
8. To know resources available and to seek the right ones at the right time.

It might be well to give some thought to the role the public health nurse can play in the cancer prevention program. The very nature of her work in dealing with all age groups, makes her a potential force in cancer control. Perhaps the fact that the early symptoms do not manifest themselves in any definite way, but are recognized as rather vague disturbances, is one of the reasons that the trouble is so far advanced when finally diagnosed. The case finding of early cancer is often dependent upon the nurse's knowledge of the so-called precancerous conditions.

It is well, too, to consider what can presently be offered to the patient in relation to home nursing care (1) in the urban area (2) in the rural area. In Nova Scotia and New Brunswick for example there are 32 Victorian Order branches. These are, for the most part, in the urban areas. There is a definite need for service in the fringe areas. An effort is being made to meet this need. Some of these fringe areas might well be classed as rural.

It has been interesting to watch the progress of the Northumberland-Durham Health Unit in Ontario where a nursing service has been incorporated with the public health program. This has required mainly just a rearrangement of work. The calls for nursing care are limited to physicians' referrals and special cases. No dressings or medications are supplied. Written or verbal reports are given to the doctors. Assistance is provided at home deliveries. It has been found that there is more demand for care of those with long-term illness than the acutely ill.

There is a need for unceasing effort in cancer control; for provision of the best nursing care possible for the cancer patient in the home and for *more nurses* in *more places* to help.

March, 1956 Issue

Several requests have been received at the *Journal* office for a copy of the March, 1956 issue. Our reserve supply of this number is completely exhausted. We wonder if there are any subscribers who would be willing to send us their copy so that we may mail them to the university libraries that appear to have lost their copies.

If you have a copy to spare, please put it into the envelope from which you have just removed the copy you are reading. Do not seal or put Scotch tape on the flap. Lightly cross out your name and run an arrow up to our corner address. We will pay the return postage when the copy reaches us.

* * *

According to a recent health survey, women average about six visits to their doctors in a year as compared to less than four per year for men. These extra visits women make seem to pay off for they live, on the average, about five years longer than men.

— *Blue Print for Health*

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CNJ

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To Serve Your Family Better

The Organization and Operation of a Cancer Welfare Program

ELIZABETH A. HARTLING

DURING THE MID-VICTORIAN period, and due to the expansion of social responsibility caused partly by the changing conditions brought about by the Industrial Revolution and other causes, assistance to the poor and needy which had been looked after by the "lady of the manor" or the responsible landowner on a very personal and satisfactory basis, fell into the hands of organized groups of citizens. In England, particularly at that time, societies of all kinds, many of them semi-religious, sprang up and the good causes were varied and often peculiar. All of these, of course, were financed by personal subscriptions. Those of you who are familiar with Dickens' *Christmas Carol*, will remember how Mr. Scrooge refused to be influenced by the season and to subscribe to a certain Society, the members of which were interested in providing Christmas cheer to the inhabitants of workhouses. Except for the efforts of a few advanced persons in the centuries before, social consciousness had not advanced to mass alleviation of suffering on a more impersonal basis.

At the beginning of this present century, another development took place. This was the result of a new attitude towards physical health that emerged from the scientific advances of the 19th century. This development was the voluntary health agency, or the "Citizens' Attack on Disease." Such societies are composed of members drawn mainly from non-professional groups but who are guided in their varied attacks by the medical and nursing professions.

The voluntary health agencies are highly specialized expressions of the common human impulse to relieve suffering. Invariably, each one has restricted its interest to one particular disease or disability that affects large numbers of people. They are concerned with maintaining public health at a high level and the prevention or reduction of sickness and needless early death. No two of these organizations are quite alike. All have in common the desire to serve and to be usefully occupied, and the realization that an improvement in health standards is something to be achieved through joint efforts. In most of these societies, paid employees are few. The volunteer workers are numbered in the thousands and the hours of work and effort in the millions.

A rough definition of the voluntary health agency, then, could be that it is administered by volunteer officers and board; that it collects funds for its support from the public; that it expends its funds on a program of health education, care and assistance, advancement of research or legislation related to health — usually a combination of all these activities. It must be efficiently conducted with a properly supervised program that does not impinge on the medical field or prerogatives and fulfills a need that is not being met by any other agency. It should be prepared to work itself out of existence when the purposes for which it was set up have been accomplished, or in reference to welfare, when the work has been taken over by the government. The volunteers in these agencies act as the interpreters of health in the community. They bring expert knowledge and training to the objectives and release the small numbers of paid staff for other work.

The Canadian Cancer Society fits quite neatly into the outline. Before proceeding with a detailed description of the welfare work, it would be well to look for a moment at the picture as a whole.

In 1938, the Canadian Medical Association came to the conclusion that some action must be taken to counter-

Miss Hartling is the executive secretary of the Nova Scotia Division of the Canadian Cancer Society.

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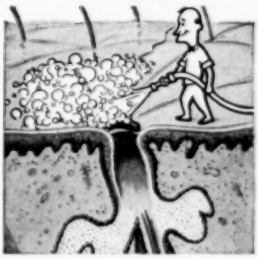

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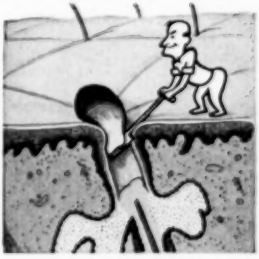

◂ Penetrate and soften comedones, unblocking the pores and facilitating removal of sebum plugs.

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act the rising mortality rate of cancer in Canada. They had discovered that too many patients were coming to doctors for treatment many months after the first symptoms of the disease had appeared. In most cases, the disease had passed into the late stages and nothing much could be done except to relieve suffering. Fear, ignorance, carelessness, superstition were some of the causes of delay. All the great strides made in surgery, the wonderful new x-ray equipment and the use of radium could not prolong the life of the man or woman who had left until too late their visit to the doctor.

It was decided that the cooperation of the lay public was essential. Everyone should be made aware of the facts about cancer — the most important of which was that many cancers can be cured if diagnosed and treated early. Thus, just before the last war, the Canadian Cancer Society was born. Not a great deal of progress was made until the conclusion of the war as public attention was diverted. In 1946, divisional headquarters were set up in most of the provinces and the work began.

It should be borne in mind that the Society is primarily a lay organization, operated by volunteers under medical sponsorship and supported by public memberships. Its prime function was, and still is, public education. It is nonpolitical and does not receive government funds for its support.

Next to the all-important educational program is the vital problem of research. In Canada and other parts of the world, workers are engaged tirelessly in trying to discover the cause of cancer, how treatment may be improved, how the disease may be detected more easily in its early stages. Research is expensive. Those who take part in it must be very highly trained. In Canada all cancer research is supervised by the National Cancer Institute of Canada. The Institute is affiliated with the Canadian Cancer Society under a common executive director. Research is carried on mainly in the university centres. It is sponsored by the universities and financed mainly by funds provided by the Canadian Cancer Society. In addition, the Society provides scholarships and fellowships for the postgraduate training of young doctors in radiology, pathology and other medical fields to provide Canada with badly needed workers in the cancer program.

We have now dealt with the two basic objectives of the Society, but in 1947 another problem arose in all the provinces — that of the care and comfort of cancer patients. It was not originally intended that the Society should undertake welfare work. It was understood that Canada was fortunate in having many welfare agencies of all types. However, after many consultations with other organizations it was found that none of them was concerned with the particular problems of the person suffering from cancer. Consequently, a program of service was undertaken that absorbs the time and thought of hundreds of volunteers and at least a third of the Society's income today.

This is the work that interests most volunteers because they can see the results of their labors. The results from educational activity are intangible. The results of research will come tomorrow or next year perhaps, but Mrs. Jones knows that the dressings she makes will keep Mr. Smith clean and comfortable *today*.

All the activities of the Society, including welfare, are carried on in various parts of a province by units. A unit is comprised of all the members of the Society in a particular locality. A member is a person who has paid a membership fee to the Society of $1.00 or more in any one year. The members of the unit are called together at a public meeting and elect an executive and officers to administer the work of cancer control in the area until the next annual meeting.

One of the most important members of the unit executive is the welfare chairman. This person may have working with her or him, particularly in a large unit, a cancer dressings convener; a loan cupboard convener; a transportation convener, etc. Each of these in turn will be in charge of a large number of active volunteers. There are, for example, 33 units in the province of Nova Scotia at the present time and the welfare work they do is enormous. These units have found over the years that welfare work has an educational value as well. It is im-

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possible for large numbers of people to be associated with a project without many of them (and their relatives and friends) absorbing the purposes and objectives of the cause.

Each welfare service given by the Society has developed as the need arose. Development has been slow by the trial and error method and on a very personal basis. A special tribute must be paid here to the volunteers, most of them without training in social work. Without them the program could neither have acquired a pattern, nor could it be carried on at all.

Cancer Dressings

The oldest of the various welfare services is the cancer dressing program. In this particular province, it requires the time of over 2000 women regularly, week after week, throughout the year. The material is purchased in bulk by the division and distributed to the units. The volunteer groups of women make up the dressings, mainly standard sizes of cellucotton or combination padding and gauze. These are stored for distribution to patients in the unit area. Any surplus is forwarded to headquarters for use in districts where there is no organized group. The dressings are supplied free of charge to all cancer patients. The application for them is made to the Society by the doctor in charge of the patient or some other authorized agency or individual. Should application for dressings or any other service be made by the patient or relatives, the welfare chairman always contacts the doctor first for his permission and advice. Should the patient be unaware of the nature of his disease, blank labels are always used. Never to our knowledge has a patient been given information about his condition by our volunteers.

Loan Cupboard

Very early, requests began to come in for bedside nursing equipment — gatch beds, rubber sheets, linen and dozens of other items. In spite of the fact that the Red Cross had loan cupboard supply depots, it was found necessary for the Society to set up supply cupboards in most of the larger units. Again, the supplies are given or loaned to patients without charge or formal referral.

Transportation

For many years the Society in Nova Scotia, through its units, assisted needy patients with the costs of travel to and from treatment centres. By 1956 the cost of this service had risen to approximately $8,000 per year and was steadily increasing. Following the opening of the Nova Scotia Tumor Clinic, the increased travelling of patients for treatment and check-up from all parts of the province expanded to a great degree. Finally on July 15, 1956 the government of Nova Scotia, being of the opinion that travel to treatment was a part of treatment costs, offered to pay the transportation costs to the Tumor Clinic of all cancer patients in receipt of an income of less than $3,500 per annum — *providing* that the volunteer units of the Cancer Society would undertake the administration of the program.

The mechanics of this service, of course, had been set up for many years but very quickly the transportation program began to absorb an ever-increasing amount of the time and energies of the volunteers. This will be understood, when it is noted that in 1957 the costs of transportation jumped to over $25,000 in one year. This represented travel costs of 520 patients on a nine-month basis and over 1000 separate return trips. The Society advances all monies required and is reimbursed on a quarterly basis. This reimbursement does not include the running costs which are paid by the Society itself, nor can any value be set on the time freely given by the volunteers.

Rehabilitation and Equipment

From time to time the Society has been approached to assist in the rehabilitation of patients. Artificial limbs, eyes, apparatus and equipment have been supplied without cost. Each case of this kind is considered on its special merits, bearing in mind always, that if the service can properly be provided by another agency, no over-

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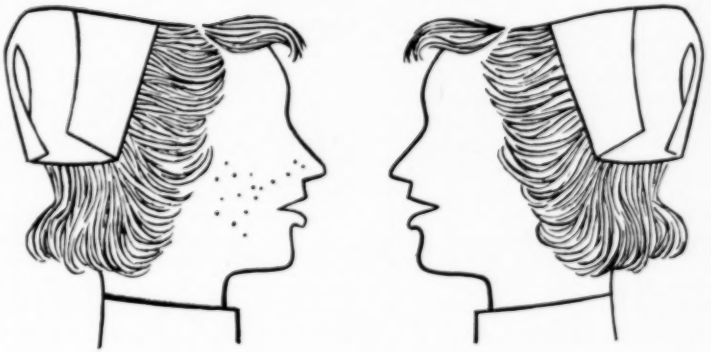
rapid improvement with 'Acnomel'



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lapping should be permitted.

Nursing and Housekeeper Care

In some areas where the Victorian Order of Nurses does not provide service, where there has been a request to supplement the care of that body or in cases of great need, the Society will assist in the payment of nursing or housekeeper care. In some cases, it has been necessary to pay for the services of a registered or practical nurse when the patient has no relatives or friends to care for him. The concern of the Society is with the patient only, of course. The trials and tribulations of the family itself are the business of other organizations. A cancer patient may suffer from neglect or ignorance. If called upon to do so, the Society will assist financially or otherwise, to see that proper care is given. Again, the case must be referred to the Society by the doctor, an authorized nursing agency or some other responsible person.

Nursing Home Costs

Here again, and in emergencies the Society can assist financially in cases of great need that cannot be handled through regular channels.

Drugs

Within the last two years, and after considerable pressure was put upon it, the Society undertook to assist in the payment of three specific pain-killing drugs in cases of great need — codeine, morphine and demerol. Applications for assistance are made to the units or to provincial headquarters and each case is studied by the provincial Welfare Committee.

Reception Rooms for Patients

In 1957, it was found that patients from remote parts of Nova Scotia visiting the Tumor Clinic, had hours to wait for return trains and buses. Many of them were strangers to Halifax, were elderly, frightened, nervous and ill, and consequently suffered considerable hardship. Therefore, a reception room for these people was opened early in the year and staffed by volunteers. These rooms are open from 9:00 A.M. to 5:30 P.M. (or as long as the patients require accommodation) every day except Saturday and Sunday. Necessary care and light refreshments are provided by the volunteers on duty.

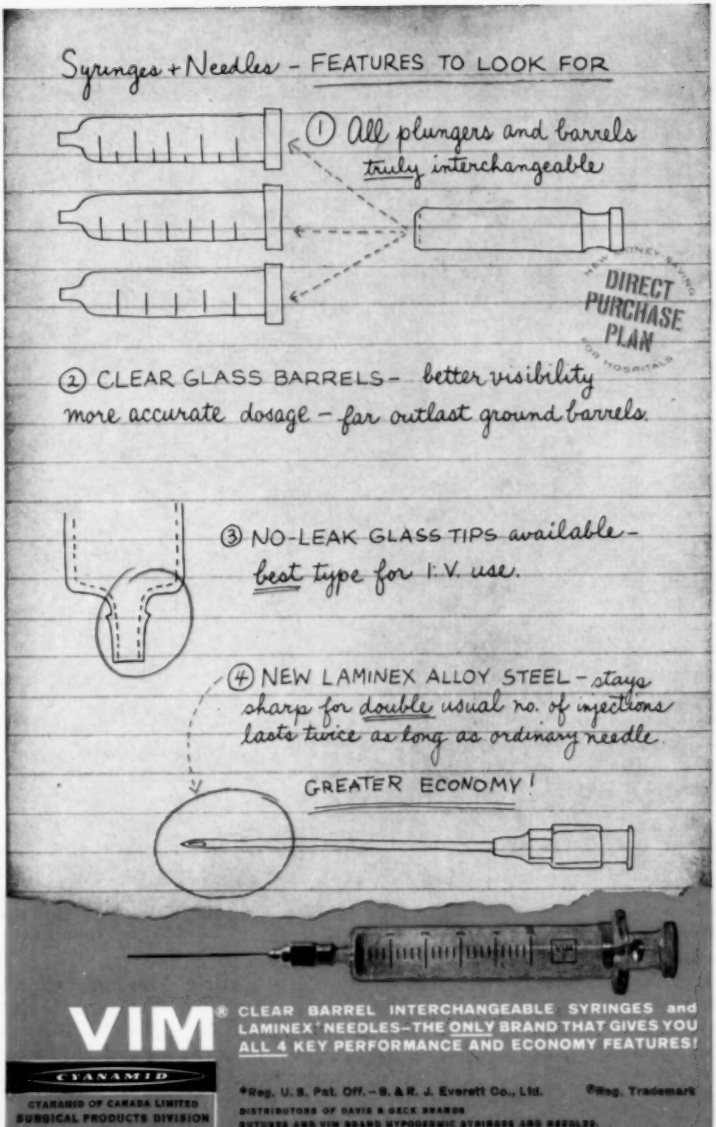
Other Services

There are many other services rendered by the volunteers of the Society. These may include provision of invalid foods. home and hospital visiting, Christmas boxes, or perhaps just sympathy and cheerful conversation. Mention should be made of three special programs carried on in the Victoria General Hospital, Halifax, that benefit all patients. These are: the Hospital Mobile Library which provides magazines and books to the wards; the entertainment program in the auditorium of the hospital twice weekly; and last, but not least, the volunteer work in the Tumor Clinic waiting rooms while patients are waiting for their various doctors. Here the volunteers provide conversation and refreshments every week of the year.

Much more could be said about the various services carried out by the volunteers of the Canadian Cancer Society in Nova Scotia. Many problems have arisen throughout the years. Most of them have been solved, we hope, to the satisfaction of all. The Society would not be in existence without the efforts of the medical profession. Its welfare program could not have been set up and could not have operated without the continual advice, guidance and assistance of the nursing profession. We have tried to carry out the program with common sense and efficiency.

Nothing so needs reforming as other people's habits. —Mark Twain

Gold is tested by fire; man by gold. —Chinese Proverb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I.L.O. Geneva Conference

From October 6 to 11, the CNA's Nursing Service Secretary, Miss **F. Lillian Campion,** was Canada's representative at a meeting of the International Labor Organization held in Geneva, Switzerland. The meeting was called to discuss the conditions of work and employment of nurses.

The International Labor Organization is the oldest of the major specialized agencies operating today in association with the United Nations. It was established in 1919 under the terms of the Treaty of Versailles. Canada has been a member of the I.L.O. since its founding. There are, in all, 79 member countries.

The organization is representative of government, employer and worker and representatives from all parts of the world participate. The I.L.O. promotes the voluntary cooperation of nations to improve labor conditions and raise living standards. It accomplishes its ideals through technical assistance, research and investigation, international labor standards, technical and industrial committees, publication of studies, periodicals and pamphlets.

Fifteen countries sent nursing representatives. These were: Austria, Brazil, Canada, Chile, Egypt, France, India, Japan, Liberia, Philippines, Sweden, Turkey, United Kingdom, U.S.S.R., United States.

The following topics were discussed:

Employment Situation —

Shortage of nurses; influence of marriage on employment; part time employment.

Conditions of Work —

Contract of employment; remuneration; social security.

Economic and Social Status —

Professional nurses; auxiliary personnel.

Recruitment including counselling and placement services.

Study Tour for British Nurses

By now the first Canadian study tour planned by the CNA for British nurses is a thing of the past.

From October 9th to 21st, Canadian nursing was host to 22 nurses from Great Britain. Unfortunately, these visitors were in Canada for only 11 days, six of which were actually working days, since the Thanksgiving holiday came within this period. It was originally hoped that the tour would allow the nurses approximately 3 weeks in Canada, giving a week in Montreal, Ottawa and Toronto.

Due to changes in travel arrangements as planned in Great Britain, the tour was considerably shortened.

Plans were made by the CNA in cooperation with the provincial nurses' associations in Quebec and Ontario to include observation visits to meet the requests of the nurses.

Requests included observation of administrative procedures, nursing education, surgery, obstetrics, child health, psychiatry, auxiliary personnel and nursing associations.

Miss **Laurie McColl,** recently appointed assistant secretary in National Office met the party on arrival in Montreal, accompanied the tour and was thus able by group discussions to assist the nurses in sharing their experiences and in interpreting Canadian nursing.

Social activities included receptions given by the President, Miss **Alice Girard** in Montreal and the CNA in Ottawa. Sightseeing tours and a trip

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to Niagara Falls and to Quebec City, where the nurses boarded the *Empress of France,* completed the tour.

It is hoped this first tour has opened the way for a regular plan of tours. It has been a pleasure to carry out these arrangements and it is hoped it was beneficial and enjoyable for the nurses concerned.

Pilot Project's Board of Review Meets

The first meeting of the Board of Review was held October 22 - 24 in Ottawa. The purpose of this meeting, was to provide an orientation for the members as well as a review of the survey reports of the first schools to be visited. After discussion of each report, the Board compiled, for each school, a list of the areas of strength and areas requiring study and improvement.

The Board of Review, selected by the Executive Committee, is composed of 10 nurse members and represents all regions in Canada. The majority of these members are directors of nursing or directors of nursing education. There are also representatives from a university school, public health, an official school visitor and the religious sisterhoods. The senior bilingual evaluator, **Sister Denise Lefebvre** attended. At least two other members of the Board of Review are bilingual. The Canadian Medical Association and the Canadian Hospital Association were invited to send one member each on a non-voting basis.

The next meeting of the Board of Review will be held in April or May of 1959.

Schools Surveyed

In addition to preliminary visits by the director to all schools participating in the Pilot Project, ten schools have had a complete survey. These surveys have included schools in the Atlantic Provinces, Quebec, Ontario, Manitoba and Saskatchewan.

Montreal Graduation Exercises

On September 7th, 476 graduate nurses from the 12 French language schools of nursing on the Island of Montreal received their graduation diplomas. This impressive evening ceremony took place in Notre Dame Church where His Eminence Cardinal Paul-Emile Léger, Archibishop of Montreal, presented each nurse with her diploma.

For the past five years, these schools have held this joint graduation, which is followed by a reception given by each school of nursing in honor of the graduates. The CNA welcomes these new members to the Association and offers them congratulations for future success in their chosen profession.

The Chairmen Meet

The five National Committee chairmen met with the President in September to review the function of their respective committees as outlined in the CNA By-laws. The proposed activities for the present biennium were studied in the light of the available budget allocated to each committee.

Suggestions were received for the appointment of additional members to each committee as outlined in the By-laws.

By now, plans are being developed for the first meetings. As is customary, most committees will meet with the complete membership representing each province in attendance and will initiate projects. As indicated, the Core Committee, consisting of members living in the vicinity of the chairman, will meet to carry on the work throughout the biennium.

Chairman — Committee on Public Relations

We are pleased to announce that Miss **Ethel Gordon** has been appointed as chairman of the Committee on Public Relations for the 1958 - 1960 biennium.

Miss Gordon holds the position of Chief Supervisor of Nursing Counsellors, Civil Service Health Division, Department of National Health and Welfare. During the last biennium she was the capable chairman of the Arrangements Committee for the CNA Anniversary Convention. We are happy to welcome her as chairman and as a member of the CNA Executive Committee.

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Le Nursing à travers le pays

Conférence de l'O.I.T. à Genève

Du 6 au 11 octobre, Mlle **F. Lillian Campion**, secrétaire du Service du Nursing à l'Association des Infirmières Canadiennes, représenta le Canada à l'assemblée de l'Organisation Internationale du Travail qui se tint à Genève, Suisse. La réunion fut convoquée dans le but de discuter des conditions de travail et d'emploi des infirmières.

L'Organisation Internationale du Travail est la plus ancienne et une des plus importantes organisations spécialisées fonctionnant aujourd'hui en collaboration avec les Nations Unies. Cette organisation fut établie en 1919, en vertu du Traité de Versailles. Le Canada est membre de l'O.I.T. depuis sa fondation qui comprend en tout 79 pays membres.

L'Organisation représente les gouvernements, les employeurs et les employés de toutes les parties du monde. L'O.I.T. incite les nations à coopérer volontairement à l'amélioration des conditions de travail et au relèvement continuel du niveau de vie. Pour atteindre ce but, on a recours à l'assistance technique, à la recherche et aux enquêtes, à l'établissement de normes internationales dans le travail, à la formation de comités techniques et industriels, à la publication d'études, de périodiques, etc.

Quinze pays y ont envoyé des infirmières comme représentantes. Ce sont: l'Autriche, le Brésil, le Canada, le Chili, l'Egypte, la France, l'Inde, le Japon, le Libéria, les Philippines, la Suède, la Turquie, la Royaume-Uni, l'U.R.S.S. et les Etats-Unis. Les points suivants furent discutés:

Emploi — Pénurie d'infirmières; influence du mariage sur l'emploi; emploi à temps partiel.

Conditions de travail — Contrat de travail; rémunération; sécurité sociale.

Statut économique et social — Infirmières professionnelles; personnel auxiliaire.

Recrutement, y compris service d'orientation et de placement.

Voyage d'études d'infirmières britanniques

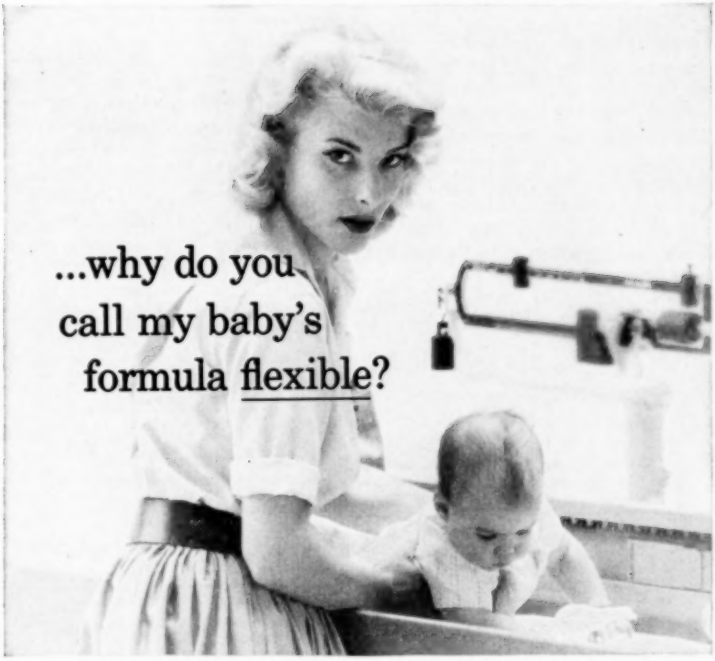
Le voyage d'études organisé par l'A.I.C. au bénéfice d'infirmières britanniques est maintenant chose du passé. Du 9 au 21 octobre, les infirmières canadiennes ont reçu 22 infirmières de Grande-Bretagne. Malheureusement, ce groupe n'a passé que 11 jours au Canada dont seulement six d'études puisque le congé de l'Action de Grâce tombait durant leur séjour. Nous espérions que la durée de ce voyage serait de trois semaines, donnant ainsi une semaine à Montréal, une à Ottawa et une à Toronto. Des changements apportés dans l'organisation du voyage, en Grande-Bretagne, ont considérablement raccourci le séjour de ce groupe au Canada.

Un programme avait été tracé par l'A.I.C. en collaboration avec les associations provinciales d'infirmières du Québec et de l'Ontario, comprenant des visites d'observation pouvant répondre aux désirs de ces infirmières, à savoir: observation de procédés d'administration, éducation en nursing, obstétrique, hygiène infantile, psychiatrie, personnel auxiliaire et associations d'infirmières.

Mlle **Laurie McColl**, récemment nommée secrétaire adjointe au Bureau de l'Association des infirmières canadiennes, a reçu le groupe à son arrivée à Montréal et l'a accompagné dans sa tournée; elle a ainsi pu, au moyen de discussions en groupes, faciliter à ces infirmières l'interprétation du nursing tel que pratiqué au Canada.

Au point de vue récréatif, une réception fut donnée à Montréal par Mlle **Alice Girard**, présidente et, à Ottawa, par l'A.I.C. Un voyage aux chutes Niagara et à Québec a été organisé et, de Québec, terme de leur voyage, ces infirmières se sont embarquées à bord de l'*Empress of France*.

Ce premier voyage d'études sera-t-il le



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Assemblée du Bureau de Revision du Projet d'Accréditation des Ecoles d'Infirmières

La première réunion du Bureau de Revision eut lieu du 22 au 24 octobre, à Ottawa. Le but de cette réunion était d'orienter les membres aussi bien que de prendre connaissance des rapports d'enquêtes faites dans les premières écoles visitées. Après discussion sur chacun des rapports, le Bureau compila, pour chaque école, une liste des points jugés bons et de ceux demandant une étude plus approfondie et devant être améliorés.

Le Bureau de Revision, choisi par le Comité Exécutif, se compose de dix infirmières représentant toutes les régions du Canada. Ces membres sont en grande partie des directrices de service du nursing ou directrices de l'enseignement. Il y a aussi des représentantes des écoles universitaires, de l'hygiène publique, une visiteuse officielle d'écoles d'infirmières et de communautés religieuses hospitalières. **Soeur Denise Lefebvre**, évaluatrice bilingue, était présente. Il y a au moins deux autres membres du Bureau qui sont bilingues. L'Association Médicale Canadienne et l'Association Canadienne des Hôpitaux furent invitées à s'y faire représenter par chacune un membre, ces représentants n'avaient pas droit de vote.

La prochaine réunion du Bureau de Revision aura lieu en avril ou mai 1959.

Ecoles visitées

En plus de la visite préliminaire faite par la directrice à toutes les écoles participant au Projet d'Evaluation, dix écoles ont été visitées et évaluées, soit dans les Maritimes, Québec, Ontario, Manitoba et Saskatchewan.

Collation de diplômes chez les Infirmières à Montréal

Le 7 septembre, 476 diplômées de 12 écoles d'infirmières de l'Ile de Montréal recevaient leur parchemin. Cette impressionnante cérémonie se déroulait en l'église Notre-Dame où Son Eminence le Cardinal Paul-Emile Léger, Archevêque de Montréal, présentait à chacune le diplôme de son école.

Depuis cinq ans, ces écoles ont une collation générale de diplômes laquelle est suivie d'une réception donnée par chaque école, en l'honneur des nouvelles diplômées. L'Association des infirmières canadiennes souhaite la bienvenue à ces futurs membres de l'Association et leur offre ses meilleures voeux de succès dans la carrière qu'elles ont choisie.

Les convocatrices se réunissent

Les convocatrices des cinq comités nationaux et la présidente de l'A.I.C. se sont réunies en septembre dans le but de reviser les fonctions de leurs comités respectifs telles que définies par les règlements de l'A.I.C. Les projets des divers comités ont été étudiés à la lumière du budget de chacun.

Des suggestions furent faites concernant l'addition d'un nouveau membre à chacun des comités, tel que déterminé par les règlements. L'on est actuellement à organiser la première réunion de ces comités. Il est d'usage que tous les membres représentant les provinces assistent à la première séance de ces comités et participent à l'élaboration de projets. Par la suite, un comité restreint, composé de membres de la région dans laquelle habite la convocatrice, se réunira pour poursuivre le travail pendant la période biennale.

Convocatrice — Comité des Relations Extérieures

Il nous fait plaisir d'annoncer que Mlle **Ethel Gordon** a été nommée convocatrice du Comité des Relations Extérieures pour la période biennale 1958-60. Mlle Gordon est surveillante en chef des consultantes en nursing, division de la santé du Service Civil, Ministère de la Santé Nationale et du Bien-Etre social. C'est Mlle Gordon qui, à titre de convocatrice du comité d'organisation s'est occupée des préparatifs du Congrès-Anniversaire de l'A.I.C. Nous sommes heureuse de lui souhaiter la plus cordiale bienvenue au Comité Exécutif.

Vos emplettes de Noël

Ne manquez pas d'inscrire sur votre liste de cadeaux une jolie cuiller à café en argent ornée d'une réplique du sceau de l'A.I.C. Les profits de cette vente vont au fonds du Projet d'Evaluation des Ecoles d'Infirmières; le prix en est de $2.50.

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Nursing Profiles

Last month **Mabel Victoria Antonini**, "Vicky" to her friends, began her duties as the new executive secretary-treasurer of the Saskatchewan Registered Nurses' Association. Although born in Ontario, she received a good share of her general education in Regina and is a graduate of the Regina General Hospital.

In 1940 Miss Antonini was awarded the Carss scholarship by her school of nursing and enrolled in the McGill School for Graduate Nurses for her first year of post-graduate study in teaching and supervision. In 1946 she returned to McGill and completed requirements for her bachelor's degree in nursing.

Her professional career, except for the years 1943-46 when she served overseas as a nursing sister with the R.C.A.M.C., has been devoted to pediatric nursing. Starting as head nurse of the children's ward in her home hospital, Miss Antonini later spent two years as clinical instructress in pediatrics at the Vancouver General Hospital. She returned to the Regina General in 1949 as clinical instructor in pediatrics and for the past year she was administrative supervisor in the same unit.

Active in the affairs of her alumnae association and her provincial nursing association, Miss Antonini enjoys a variety of sports in her off-duty time — curling, golf and badminton leading the list. She is a member of Altrusa as well.

(John Toth, Regina)

M. Victoria Antonini

This summer the Montreal Central School for Nursing Assistants, Queen Mary Veterans' Hospital, graduated its last class. It is a matter of sincere regret to the hospitals in this area and farther afield that it has been found necessary to discontinue the project. Under the very capable guidance of its director, **Emily Rosalie Groenewald**, the school had developed an educational program that produced graduates acknowledged to be exceptionally well prepared for their field of service. The Association of Nurses of Quebec will also miss the assistance and counsel always so generously given by the director through her work on various committees of the organization. Quebec's loss is very definitely New Brunswick's gain and her many friends will join in wishing Miss Groenewald much satisfaction and happiness in her new position as assistant director of the D.V.A. Hospital, Lancaster, N.B.

Born in South Africa, Miss Groenewald received her early education there before entering the Women's College Hospital, Toronto for her professional preparation. She is a graduate in teaching and supervision

Emily R. Groenewald

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*Benson, R. A., and associates. J. Pediat, 34:49, 1949
Klarmann, E. G., and Wright, E. S., Soap San. Chem. 22:125, 1946

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of the McGill School for Graduate Nurses and much of her professional career has been devoted to nursing education. Prior to her military service in World War II, she served as instructor of nurses at Guelph General Hospital, 1930-36; medical supervisor, Children's Memorial Hospital, Montreal (now Montreal Children's Hospital), and as nursing arts instructor, Winnipeg General Hospital. In 1941 she went overseas as one of the 300 nursing sisters forming the South African Military Nursing Service and served in the Union of South Africa and Italy until 1945. On her return to Canada she became the educational assistant at the D.V.A. Hospital, Ste Anne de Bellevue, P.Q.

In 1951 Miss Groenewald joined the Department of Veterans' affairs head office, Ottawa. During the year that she spent there, she assisted extensively in the preparation of a manual, "Nursing Aspects of Atomic Warfare," that is presently the chief reference and guide in training nurses for civil defence across the country. In 1952 she became director of the Montreal Central School for Nursing Assistants and somehow, in the course of a busy six years, she found time to draft a major section of the revised edition of the home nursing manual for the St. John Ambulance Association.

Her professional duties have understandably made it difficult at times for her to keep up as many activities socially as she would like. However Miss Groenewald has been a member of Soroptomist Club of Greater Montreal since 1953; enjoys music, travel, reading and the theatre. We also know that, no matter how good a Maritimer she may become, her loyalty to Montreal's "Alouettes" and "Les Canadiens" will never change.

The Registered Nurses' Association of Ontario has been greatly concerned in the past months about the question of labor relations representation. In the provincial office, this problem has become largely the responsibility of **Mary (Fidler) Strong**, the consultant in personnel relations.

MARY F. STRONG

A native of Ontario and a graduate of the University of Toronto, Mrs. Strong obtained her professional training at the Toronto General Hospital. Private nursing and general duty were followed by experience as a head nurse on a surgical ward in her home hospital. From 1930-33, she worked on the staff of the Rockefeller Institute Hospital, New York but then she came back to T.O.H. and her duties as head nurse again until 1936.

In 1947 private nursing claimed her attention once more and Mrs. Strong remained in this field until 1951 when she joined the provincial office staff of the R.N.A.O. — first as a member of the registration department, later as assistant registrar, moving into her present role in May, 1957. In preparation for the duties that became hers as a result of this latter appointment, Mrs. Strong returned to the University of Toronto for a time to study problems in personnel administration and union management relations.

Her background of hospital experience, her special academic preparation, her intimate knowledge of her provincial association and the ease with which she meets and deals with others have fitted Mrs. Strong particularly well for the very important role to which she has been assigned.

Joyce Nevitt has been appointed lecturer in public health nursing at the University of Western Ontario.

Born in England, Miss Nevitt began her education in Jamaica, British West Indies and then returned to England to complete her basic studies. A year travelling throughout Europe preceded entrance into the school of nursing of Fulham Hospital, Hammersmith, London, Eng. from which she graduated in 1943. In 1944 she went to the Royal National Ear, Nose and Throat Hospital, London where she remained for some time first as a student and subsequently as a staff nurse.

Shortly after coming to Canada Miss Nevitt enrolled at McMaster University and obtained her B.Sc.N. in 1949. For a short time she was a head nurse and lecturer in eye, ear, nose and throat nursing at Toronto Western Hospital before turning to private nursing. Public health nursing next claimed her attention and, in preparation for this field, Miss Nevitt obtained her certificate in public health nursing from University

JOYCE NEVITT

of Toronto. Her first appointment was to Halton County Health Unit where she worked during 1953-57 until called to the Township of Tarentorus in the Sault Ste Marie area where she organized a new health service.

An active member of various professional organizations, Miss Nevitt also has a wide variety of outside interests. She has spent some time studying oil painting and ceramics, is interested in music and has expressed this through church choir work and piano study.

Dorothy Dick has joined the staff of Winnipeg General Hospital as clinical coordinator. A graduate of Royal Victoria Hospital, Montreal, she obtained her certificate in public health nursing from the McGill School for Graduate Nurses in 1942. In 1948 Miss Dick obtained her B.Sc. from Columbia University and in 1954 completed requirements for her Master's degree from the same University.

She was with the City Health Department in Winnipeg for five years and for the past nine has been an instructor in the School of Nursing Education, University of Manitoba. Her present duties as coordinator are to direct educational programs for the graduate nurse staff and the orderlies of the hospital.

* * *

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— THOMAS MOORE in *How to Make a Good Politician*

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In Memoriam

Jean Mary Chesher who graduated from the Royal Jubilee Hospital, Victoria in 1955 died recently.

* * *

Charlotte Leith Counsell, a graduate of the General Hospital, Winnipeg in 1927, died on June 13, 1958.

* * *

Simone (Brunet) Crawford who graduated from Notre Dame Hospital, Montreal in 1940 died on August 8, 1958 as the result of a street accident. At the time of her death she was in charge of the recovery room of Notre Dame Hospital.

* * *

Blanche Davidson who graduated in 1925 from St. Paul's Hospital, Vancouver died suddenly. She was formerly an industrial nurse on the staff of Phoenix Cannery of A.B.C. Packing Co.

* * *

Gracia Deslauriers, a graduate of the General Hospital, Ottawa in 1920 died on August 13, 1958. Ill health forced her retirement from nursing a few years following her graduation.

* * *

Marguerite Dickie who graduated from the General Hospital, Oshawa, Ont. in 1925 died on December 16, 1957.

* * *

Emily Geraldine Dwane a graduate of the General Hospital, Montreal in 1923 died on May 23, 1958.

* * *

Mary Fogarty who graduated from the General Hospital, Winnipeg in 1920 died this year.

* * *

Ruth A. Hillman, a graduate of the General Hospital, Hamilton in 1950, died this year. She was engaged in occupational health nursing.

* * *

Grace (Cox-Smith) Jackson a graduate of the General Hospital, Brandon in 1920 died on August 20, 1958.

* * *

Clara Jasper who graduated from the General Hospital, Winnipeg in 1921 died on June 5, 1958.

* * *

Pauline (Charette) Lachapelle, a graduate of St. Elizabeth School of Nursing, St. Joseph's Hospital, Sudbury in 1955 died on August 29, 1958.

Florence Vernon (Van Camp) Lander who graduated in Stratford, Ont. died August 27, 1958. She had been a member of the board of Women's College Hospital, Toronto for 16 years.

* * *

Alma Lapp who graduated from the Connaught Training School for Nurses, Weston, Ont. in 1931 died this year.

* * *

Cora (Shaw) McGoun a graduate of the Royal Victoria Hospital, Montreal in 1919 died on September 12, 1958.

* * *

Isabelle Pearl McKenzie who graduated from the General Hospital, Winnipeg in 1921 died in July, 1958.

* * *

Margaret Ellen (Waterhouse) MacConnell a graduate of the Toronto Western Hospital in 1898 died on August 25, 1958. She was the first student nurse to enrol after the organization of the school of nursing in 1896.

* * *

Olive Frances (Garland) Manders who graduated from St. Luke's Hospital, New York died in August, 1958. During World War I, Mrs. Manders served overseas in England and in France. She was awarded the Royal Red Cross for her work and returned to Canada to become matron of Deer Lodge Hospital, Winnipeg. She remained in that position for 15 years.

* * *

Eva M. Murphy a graduate of St. Joseph's Hospital, Guelph in 1911 died recently. Much of her professional life had been spent in private nursing.

* * *

Gertrude Beatrice (Harvey) Nash who graduated from St. Paul's Hospital, Vancouver in 1932 died recently.

* * *

Doreen (Sherman) Piirainen who graduated from Toronto Western Hospital in 1939 died in August, 1958.

* * *

Edna (Fischer) Richardson who graduated from The Mack Training School for Nurses, St. Catharines, Ont. died on July 27, 1958.

* * *

Janet Clarice (Gordon) Robson a graduate of the Royal Victoria Hospital, Montreal in 1941 died September 10, 1958.

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Annie (Fiddis) Sinclair who graduated from Victoria General Hospital, Winnipeg in 1928, died July 19, 1958 after a long illness.

* * *

Jessie Isabel Smith a graduate of the General Hospital, Winnipeg in 1910 died August 20, 1958. During World War I she had served overseas with the Canadian medical services.

* * *

Mary (Gowanlock) Smith who graduated from the General Hospital, Winnipeg in 1928 died in December, 1957.

* * *

Veronica (Vera) Sullivan who graduated from St. Joseph's Hospital, Hamilton in 1929 died on September 3, 1958. For the past 14 years she had been doing occupational health nursing.

* * *

Margaret (Robertson) Valentine a graduate of the General Hospital, Winnipeg in 1914 died on January 9, 1958.

Colostomy

ONE OF THE MOST SUCCESSFUL attempts to rehabilitate a cancer victim revolves around the patient with a colostomy. To be most effective teaching must begin early. The first step should be adequate preoperative mental preparation towards acceptance of the colostomy.

Usually the patient worries a great deal over control of the colostomy and embarrassment from odors or accidental discharge of fecal contents. Then, too, one must be prepared to encounter disgust at the appearance of the colostomy; abhorrence of the details necessary in its care; worry over social acceptance and many other anxieties. Many of these problems fall within the scope of nursing care.

The task of regulating the movements of the colostomy must begin well in advance of discharge from the hospital. The use of irrigations may be the method of control favored. The patient must be taught and encouraged to undertake his own care. He must be helped to gain skill in performing his own irrigations; be instructed in changing and disposing of dressings; must be shown how to care for the skin around the colostomy. Regardless of the thoroughness of his preoperative preparation, the reaction of his nurse to his colostomy will have an effect on the patient's postoperative adjustment. She represents the society in which he must find his place again and about which he has grave doubts in regard to finding understanding acceptance. But the patient expects even more of the nurse because of her professional preparation. If she shows any difficulty in accepting the presence of his colostomy, his doubts and fears will be correspondingly increased.

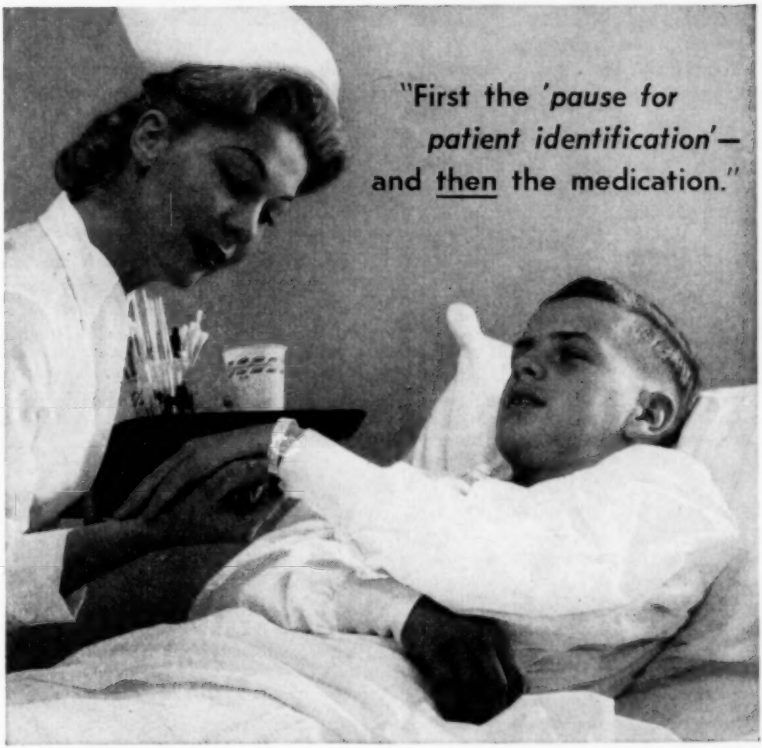
The social worker can smooth the pathway too. One of her tasks may be to approach the family and prepare them to accept the patient *with his colostomy*. The response of the family may have a very profound effect on the rapidity with which the patient takes his place in society again. Economic worries are the responsibility of the social worker also. She may be the liaison between the patient and his employer. The employer who is made aware of the patient's condition, and who is helped to understand it, is often willing to accept the worker back to his former position, if his physical condition warrants it, or even make adjustments to allow for re-employment. On the other hand the social worker may be called upon to contact the agencies able to help the family deprived of a breadwinner, faced with medical expenses, and without other financial means.

Proper diet, of course, is an important factor in controlling and living with a colostomy. The interested, understanding dietitian working with the new colostomy patient can be of much assistance. Bland diets are recommended and the patient needs help in learning to select the foods that not only will agree with his digestion but will provide a diet adequate in vitamins and minerals. Sister Irene Therese, dietitian at the Halifax Infirmary, offers a telephone consulting service to any patient having difficulty in controlling his diet at home.

* * *

Each is given a bag of tools,
A shapeless mass,
A book of rules;
And each must make,
Ere life is flown,
A stumbling-block
Or a stepping-stone.

—R. L. SHARPE



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Book Reviews

Care of the Premature Infant by Evelyn C. Lundeen, R.N. and Ralph H. Kunstadter, M.D., F.A.C.P., F.A.A.P., 367 pages. 87 illustrations. J. B. Lippincott Company, 4865 Western Ave., Montreal. 1958. Price $8.00.

Reviewed by Miss Marguerite Bateman, Teaching Supervisor, Infant's Medicine, Montreal Children's Hospital, Montreal, Quebec.

This book deals with the care of the premature infant in its entirety. It is based on the book of the same title written in 1922 and revised in 1941 by the late Dr. Julius Hess and Miss Lundeen. What has been learned in the intervening years has been added and elaborated upon in this new edition. It includes the physical layout of an up-to-date premature ward; the various types of incubators now on the market; the number of personnel required and their training in this specialized field, also a detailed account of their duties.

In the chapter on therapeutic procedures, oxygen and antibiotic therapy is outlined. Management of pathological conditions such as erythroblastosis, hyaline membrane disease, thrush, tracheo-esophageal fistula and syphilis are brought up-to-date.

New chapters on the care of the premature infant born in the home, and the follow-up care of the infant upon discharge from the hospital should prove very informative to the public health nurse.

A suggested four-week teaching course on nursing care is outlined which could be helpful to the teaching supervisor.

Parent orientation and counselling is also discussed very adequately and should assist nurses when apprehensive parents ask about immediate care of their child. This book is very instructive to those interested in caring for the premature infant in a comprehensive manner.

Hospital Ethics by Rev. Edgar Godin, J.C.L. and Rev. J. P. E. O'Hanley, Ph.D. 204 pages. Hotel Dieu Hospital, Bathurst, N.B. 1957. Price $3.50.

Reviewed by Sister M. Monica, Acting Educational Director, Charlottetown Hospital, Charlottetown, Prince Edward Island.

Hospital Ethics is the newest work in the field of medical morals; and it is the first and only complete commentary on the moral codes of the Catholic hospitals of Canada and the United States that has yet appeared. It was written primarily as a text-

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1. The Food Exchange Lists referred to are based on material in "Meal Planning with Exchange Lists" prepared by Committees of the American Diabetes Association, Inc. and The American Dietetic Association in cooperation with the Chronic Disease Program, Public Health Service, Department of Health, Education and Welfare.

book for student nurses, but intended, too, as a handbook of professional ethics for graduate nurses, medical students, doctors, hospital chaplains, and all others engaged in the medical, surgical and religious care of the sick.

In its sixty-one chapters, *Hospital Ethics* deals directly with the medico-moral, surgico-moral, and religious problems encountered daily in the care of the sick. At the beginning of each chapter, the article of the *Moral Code* (Canadian) is given on the left side of the page, and the corresponding article of *Ethical and Religious Directives for Catholic Hospitals* (American) is given on the right half. The commentary that follows introduces the problem under consideration, gives any needed definitions and explanations, and then proceeds to present a clear and concise exposition and solution of the problem.

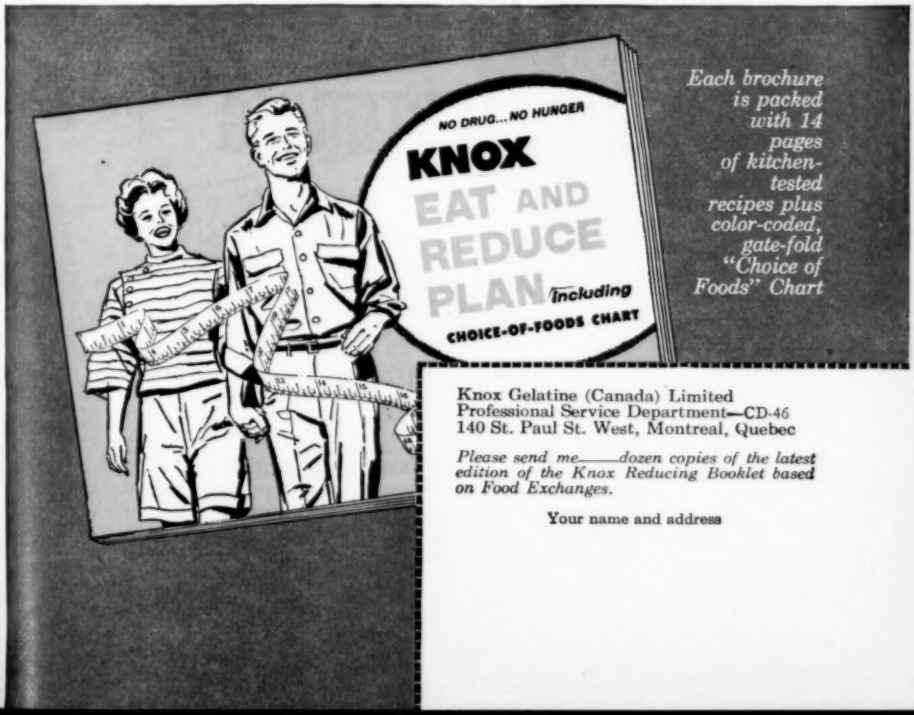
We recommend this authoritative, up-to-date, and well-written work as the most practical, most comprehensive and most concise guide in medical morals, of which we have any knowledge. It will receive a most warm welcome, we are sure, from all doctors and nurses who recognize the paramount importance of Christian ethics in the practice of medicine: from Catholics, because of their moral obligation to conform to the teachings of their Church; from non-Catholics, because of their earnest desire to conform to the rules of hospital morality of their Catholic patients; and from all, because good ethics is commonly recognized as good medicine. This work deserves a place of honor in your library.

Textbook of Psychiatric Nursing by Arthur P. Noyes, M.D., Edith M. Haydon, R.N., A.M. and Mildred van Sickel, R.N., M.S. 404 pages. Brett-Macmillan Limited, 132 Water St. S., Galt, Ont. 5th Ed. 1957. Price $4.75.

Reviewed by Miss L. Arnott, Supervisor in Psychiatry, University Hospital, Saskatoon, Saskatchewan.

The purpose of a new edition is to keep the book abreast of current psychiatric nursing thought and practice, and to emphasize the therapeutic importance of the nurse-patient relationship. Changes in content include a new chapter on the legal aspects of psychiatric nursing, and more material on the dynamic forces which influence behavior.

The authors present the specific disease entities as classified by the American Psy-



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chiatric Association, followed by a brief section on ward management at the end of each description.

In the chapter on interpersonal and related aspects of psychiatric nursing one might question the lack of emphasis placed on the development of an understanding of interpersonal skills and the effect of the social climate in the therapeutic situation. Also one might question the specific security measures suggested in the chapter on Nursing Administration and Therapy, when a much more permissive approach is being advocated and used in many centres. The content of both of these chapters would provide, a basis for interesting discussion.

This book is written from the large mental hospital point of view, which will probably make it more useful within this area than within the framework of the general hospital unit or smaller centre. The material is presented with clarity and simplicity, which makes it easily read. It would be useful as supplementary reading for students and teachers.

Nursing in Diseases of the Eye, Ear, Nose and Throat From the Manhattan Eye, Ear and Throat Hospital. 269 pages. W. B. Saunders Company, Philadelphia. 10th Ed. 1958. Price $4.50.

Reviewed by Miss Helen Tarcza, Instructor in Nursing, St. Michael's Hospital, Toronto, Ontario.

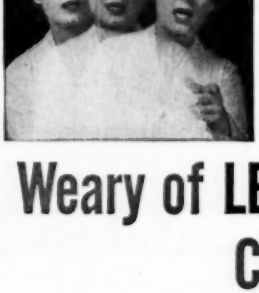
In revising this text, the authors have provided the reader with an informative and well organized concept of nursing in eye, ear, nose and throat diseases.

Material on the anatomy and physiology of the eye, ear, nose and throat is quite extensive and is accompagnied by several excellent anatomical illustrations. The information presented regarding the various conditions of these organs and the treatment of them is comprehensive, yet concise.

A number of questions appearing at the end of each chapter assist the reader in grasping important factors that are presented. A separate glossary for Part I and Part II facilitates quick reference.

The chapter on reconstructive plastic surgery of the face, although very brief, offers several sound basic principles of nursing care in this field.

The most noteworthy characteristic of this edition is that nursing principles are stressed as well as medical treatment. An excellent text for student nurses and nursing instructors.



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Gynecologic Nursing by Robert James Crossen, A.B., M.D., F.A.C.S. and Ann Jones Campbell, R.N., B.S. 260 pages. The C.V. Mosby Company, St. Louis, Mo. 5th Ed. 1956. Price $4.25.

Reviewed by Miss G. M. Gorrill, Associate Director of Nursing Education, Lethbridge Municipal Hospital, Lethbridge, Alberta.

In the preface to the fifth edition of of Gynecologic Nursing the authors state, "The decision to coordinate nursing care under the chapters concerned with diagnosis and treatment of the various diseases which was made in the previous edition has been well received; hence, we have continued to use this plan of presentation. Throughout the book we have brought up to date the details of diagnosis, treatment and nursing care."

The material included in the book is concise and easily understood. The anatomy and physiology of the reproductive system is discussed in detail. The information regarding genital malformations is adequate as is the material dealing with the nurse's responsibility in assisting with examinations and her duties in the operating room. Other topics discussed are gynecologic symptoms, pathological conditions, uterine displacements, injury to the pelvic floor, treatment of gynecologic conditions, as well as psychosomatic aspects of nursing.

There are numerous illustrations which help to clarify the various aspects of gynecologic nursing.

As was indicated in the preface, the nursing care is coordinated with diagnosis and treatment of the various diseases. There are review questions at the end of each chapter which would assist students studying gynecologic nursing. I feel that student nurses would find in this textbook the information about gynecologic nursing which they need to know.

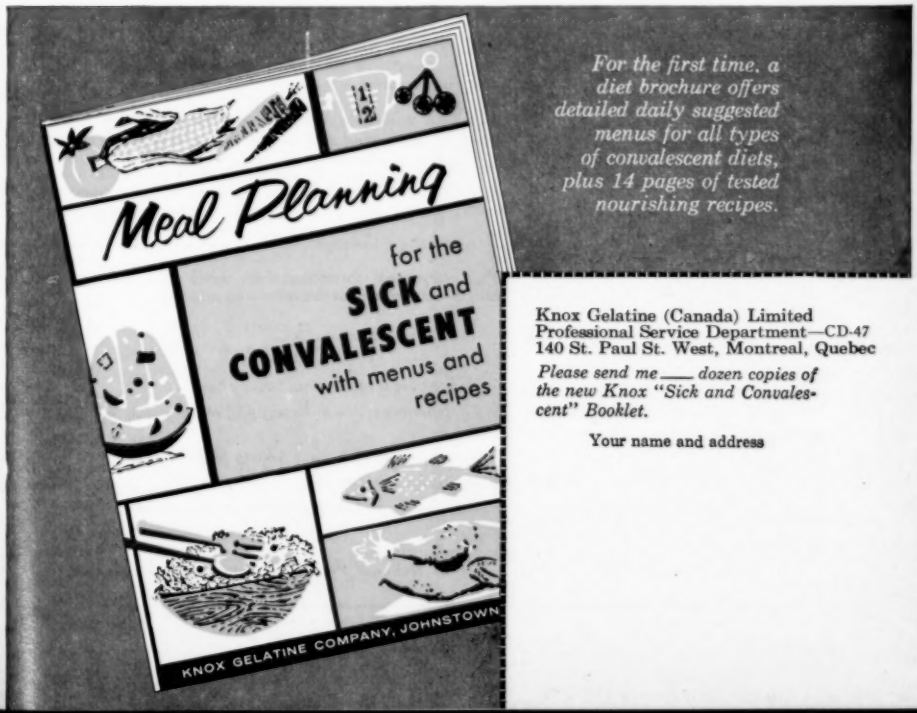
Guide for Instructors in Home Nursing. The Canadian Red Cross Society, 95 Wellesley St. East, Toronto 5., Ont.

Reviewed by Miss Margaret Holder V.O.N., Moncton, New Brunswick.

Here is a teacher's guide that will be of real assistance to graduate nurses who have undertaken the vital task of teaching home nursing skills. The aims of the course are broad and are clearly stated. They relate to:

(1) the care of the sick at home.

(2) the prevention of disease and promo-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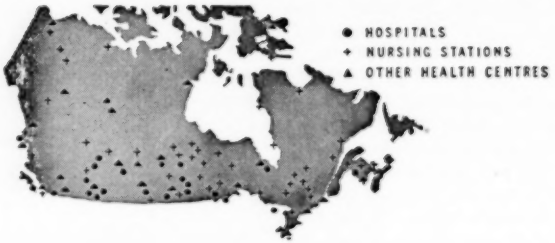

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(3) Regional Superintendent, 735 Motherwell Building, Regina, Saskatchewan.

(4) Regional Superintendent, 803-9 Confederation Life Building, 457 Main Street, Winnipeg, Manitoba.

(5) Regional Superintendent, 4th Floor, Booth Building, 165 Sparks Street, Ottawa, Ontario.

(6) Zone Supervisor of Nursing, Box 493, North Bay, Ontario.

(7) Zone Superintendent of Indian Health Services, P.O. Box 430, Upper Town, 3 Buade Street, Quebec 4, P.Q.

or

Chief, Personnel Division, Department of National Health and Welfare, Ottawa, Ontario.

tion of health in home and community,

(3) the preparation for Red Cross volunteer service in the community,

(4) the preparation of home nursing auxiliaries to serve in either peace-time or war-time disasters.

The guide is an exceedingly practical, clearly outlined teaching plan. The main emphasis is, rightly, on teaching method and general plan while the teacher is left free to develop her own content. Specific details on how to organize a class are given. All items of equipment needed during the course are listed. Reference materials, visual aids and their sources are indicated. A brief but practical section on "how to teach" offers good advice for the newcomer to group teaching.

The major section of the publication consists of twelve carefully outlined lesson plans. An additional three classes are outlined for the teaching of "Mother and Baby Care." In reviewing these teaching plans it seems possible that some are too ambitious for accomplishment in a two-hour session, for example, lessons V and IX. Similarly, to attempt to interpret "Mother and Baby Care" with any degree of satisfaction in three or four sessions, would test the skill of the most experienced teacher.

The *Guide for Instructors* will be an invaluable aid to the graduate nurse who lacks security in venturing into this field for the first time. For the experienced instructor, it should be a real time-saver in providing the general plan, the needed equipment and resource materials. The Canadian Red Cross Society is to be congratulated on developing such a fine teaching tool. It reflects 35 years of rich experience in the teaching of home nursing to Canadian citizens.

Nurse is a Neighbour by Joanna Jones. 182 pages. Wm. Collins Sons & Co. Ltd., 10 Dyas Road, Don Mills, Ont. 1958. Price $3.00.

This book gives a picture of the life and work of the English district nurse. The Canadian nurse, familiar with our pattern of public health work, will be interested in the set-up described here.

Presented in the form of a novel and as the district nurse's personal story, the reader is introduced to a system whereby the public health nurse becomes a member of the community in which she works. She is, quite literally, a neighbor to the people for whose health she is responsible. She encounters a variety of social conditions — the baby

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delivered in the gypsy encampment; the elderly sisters in the toll gate cottage — and an equal variety of medical conditions — Mrs. Mallett, the delinquent diabetic who considers the nurse's efforts to administer a daily dose of insulin as a good joke; Mrs. Wood, for whom the nurse undertakes to make arrangements for committal to a mental institution, and then discovers that she is a member of her Board. On constant call at any hour of the day or night, the district nurse must fit her personal life as best she can.

This is an entertaining and interesting story. It is equally suitable for a school of nursing library or for the personal library of a nurse or a lay person with an interest in nursing.

Perennially yours, Probie by Jo Brown. The Ryerson Press, 299 Queen Street W., Toronto, 1958. Price $3.00.

A book of cartoons based on the amusing incidents of a very junior nurse's life and designed for the sole purpose of entertainment. Nurses, student or graduate, will find this an entertaining addition to their library shelves.

An Important Milestone

THE ONTARIO CANCER INSTITUTE, incorporating the new 87-bed Princess Margaret Hospital, Toronto, is acknowledged to be one of the finest treatment and research centres in the world, certainly the most important such centre in Canada. Officially opened on September 15, 1958, the building and accommodations make provision for: research in cancer; the diagnosis and treatment of cancer; the observation of, and consultation with, persons believed to be suffering from cancer.

The Institute will be able to provide treatment to as many as 15,000 patients a year. It has a full range of radiation equipment — low, medium and up to 25 million volts. Radioactive materials — gold, phosphorus, chromium, iron and iodine — are available for research and treatment. There is a cobalt unit and also Canada's first two caesium units.

Comprehensive facilities for the care of patients requiring radiotherapy occupy most of the first four floors of this seven-storey building. Ten beds are in a children's ward and eight in a special section set aside for clinical investigation. Here are studied such problems as why cancer patients lose weight and energy.

A large number of Cancer Society volunteers provide every possible assistance to patients, including letter writing, hairdressing, and escorting patients to examination rooms. Adjacent to the hospital is a hostel, paid for by the Canadian Cancer Society, for the accommodation of patients from out

of town who do not require hospitalization but do require supervision during their daily treatments.

* * *

Our cover picture was taken in one of the treatment rooms.

* * *

In the days of Samuel Pepys, people of learning were in the great minority in the community. The concept of the importance of the individual's mind was rare. There are many factors in modern life all tending to make people conform. We are living in an age of mass production. The factors tending towards conformity, to dull uniformity, play an inordinately important role. There is probably a greater need to stress the value of the role of the non-conformist at a time like this than ever before.

—Hon. Donald Cameron

* * *

Motor vehicle accidents far outrank all other types of fatal accidents among women under 65 years of age. Most of the women are passengers or drivers rather than pedestrians. In the age range from 15-64 years, accidental injuries take twice as many female lives as diabetes and about four times as many as tuberculosis.

Home accidents are responsible for only one-fifth of fatalities — a surprisingly low proportion considering the large amount of time that women spend in the home. Very few women lose their lives in industrial establishments, only about 25 such deaths occurring in a year.

— Metropolitan Information Service

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News Notes

BRITISH COLUMBIA

Vancouver

St. Paul's Hospital

Sister Scolastica and Sister Agatha are attending the University of British Columbia this fall. Sister Ann Emily, formerly with the Central Service Department, is working in a northern hospital. G. Foote is head nurse in the nursery of the General Hospital, Medicine Hat. The fall Fashion Show was held in the auditorium of the Nurses' Home early in October. A sale of home cooking

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and a novelty booth were additional attractions.

MANITOBA

WINNIPEG

General Hospital

The summer months brought many changes. Probably the most interesting was the opening of several wards in the new north wing. There are now five wards in full operation in this wing, plus the operating and recovery rooms. The director of nursing, the administrative staff and the business staff are also in their new quarters. The official opening was held in September and the public was permitted to tour the building on the following day. The old building is to be torn down to make way for further hospital extension.

Of interest to the personnel of the hospital during the past weeks has been the establishment of a pension plan for all employees, and for the graduate nurses, the 80-hour fortnight. Many staff changes have been made too. A welcome was extended to Miss Dorothy Dick who joined the staff early in the summer as clinical coordinator. Already she is busy with her orientation program for nurses and her responsibilities for the orderly training program. Joining her in this latter area as assistant supervisor is Mr. R. Van den Berg.

Promotions to supervisory positions were received by Mrs. H. Pentland, Mr. R. Buckley and Mrs. J. Wilford. Miss L. Wiebe joined the staff as a head nurse and Mr. M. Keenan, Mrs. G. Westman and Misses R. Wong, J. McBain, W. Saunders, L. Graham and R. Stein were promoted to similar positions in their respective areas.

The first meeting of the new faculty executive took place in September under the chairmanship of the president, Miss J. Hunter. Sharing with her in the business discussion were Miss Pat Edward, vice-president; Mrs. L. Walker, secretary; Mr. R. Buckley, treasurer; Mrs. J. Yellowlees, social convener; Mrs. E. Colberg, sick visiting; and Miss R. Mulligan, program chairman. The first general meeting of the faculty was held in mid-September in the school of nursing auditorium. Again this year, the nursing faculty were guests of Mr. W. A. Murphy, chairman of the board of trustees, at a dinner at the St. Charles Country Club.

In August studies started for 97 young ladies who entered the school of nursing as the class of 1961B. Sharing in teaching duties will be Miss Irene Nordwich, who joined the educational department this fall, as science instructor; Miss Jane Edward and Mrs. E. Jewison, newly appointed assistant instructors in nursing. Directing the program is Miss Mary Hamilton who began her duties as associate director of nursing education in September.

For the class of 1958B, August 28 was "their" day. Many of this class wore the traditional red rose corsage to signify their successful completion of three years of nursing education. To all, we say congratulations, and to the 51 of the 64 who joined the staff, as graduates, we extend our welcome.

NOVA SCOTIA

WINDSOR

Payzant Memorial Hospital

Mrs. C. VanBuskirk was hostess at the quarterly meeting of the alumnae association a short time ago. Miss N. Ellis, the representative of the student nurses to the 50th CNA General Meeting was the guest speaker. Members enjoyed her detailed report of the various addresses and her description of the nursing pageant. An added pleasure of the evening was the presence of Dorothy (McClair) Rohler who was visiting the city.

ONTARIO

District 1

Windsor

Grace Hospital

J. Long and G. Dockery are attending Assumption University. J. Porter has enrolled in the University of Toronto where she will study nursing administration, while S. Suffield will attend the University of Western Ontario as a public health student. The fall class of preclinical students was welcomed to the school of nursing early in August.

District 4

St. Catharines

General Hospital

The Mack Training School alumnae association met for a potluck supper at the nurses' cottage, Port Dalhousie. At this meeting the new executive was elected for the coming year: Mrs. J. E. Porteous, hon. pres.; E. Goold, pres.; Mrs. F. Mallory, E. Culp, vice-pres.; G. Robida, Rec. sec.; D. Andrusiw, corr. sec.; L. Doucet, treas. *Committees*: B. Mitton, C. Devlin, program; E. Buchanan, publicity; N. Nazarchuck, S. Murray, Mrs. T. Elviss, ways and means; S. Jackson, H. McAleese, A. Gilbert, social; Mmes. L. Flight, F. Swayze, welfare; Mrs. R. Dinwoodie, telephone; O. Hubbert, Mrs. M. Collard, *The Canadian Nurse;* T. Derksen, Mrs. E. Snyder, news letter; Mmes. N. Durham, E. Dewar, E. Jacques, Miss H. Brown, advisory. Plans are presently underway for celebrating the 85th anniversary of the school.

QUEBEC

Montreal

The 58th annual meeting of the Canadian Tuberculosis Association was held in Quebec City in June. It marked the fifth year that the nursing section had presented a special program. There was a record number of registrants from all parts of Canada. This was the first bilingual nursing program in the association's history. Prior to the meeting, the annual reports from each province were translated into French by nurses from the Province of Quebec.

Guest speakers were Dr. Rae Chittick, director, School for Graduate Nurses, McGill University and Miss Suzanne Giroux, visitor to the French Schools of Nursing, Province of Quebec. One day was devoted to a workshop on tuberculosis nursing under the direction of Miss K. Clifford. At the annual meeting of the section, it was unanimously agreed to add a French-speaking member to the executive who would be responsible for arranging for translation of reports and other material into French. Next year's meeting will be held in Halifax.

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By Edgar Hull, and Cecilia M. Perrodin. Medical advances, nursing advances and teaching advances are reflected throughout this fifth edition. There is new material on skin diseases, diseases of the nose, of the mouth and throat, important infectious diseases. 848 pages, 172 illustrations, 1957. $6.50

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SHERBROOKE

Sherbrooke Hospital

The 1958 graduation exercises were unique in several respects. It was the school of nursing's 60th graduating class and it contained the 500th graduate. Miss Margaret Wheeler, president, A.N.P.Q. and Miss Helena Reimer, secretary-registrar, A.N.P.Q. represented the province.

Thirteen nurses received their diplomas from Lieutenant Colonel B. D. Lyon, president of the Board of Governors and Miss C. Aitkenhead, director of nursing, presented the pins. Mr. W. K. Molson, headmaster of Stanstead College, was the guest speaker and Dr. J. L. Taylor also addressed the new graduates and guests. Miss Aitkenhead led the graduates in reciting the Nightingale Pledge and reminisced briefly about the development of the school since the first class of two graduated in 1898. The educational program has expanded steadily.

Prizewinners in the class included E. Deacon, the award for general proficiency given by the medical staff and presented by its chairman, Dr. H. A. McDougall, and the James Mackinnon prize for highest marks in theory during the three-year course given by Hon. C. Gordon Mackinnon and presented by J. R. Sangter; B. Lockwood, the award for proficiency in bedside nursing given by the Ladies' Auxiliary and presented by Mrs. H. A. McDougall, president; J. Moffat, a special prize given by Mrs. E. T. Harbert and presented by Mrs. C. K. Bartlett, a graduate of 1912. R. Elkas was awarded the prize for proficiency in bedside nursing in the intermediate class given by Miss D. Seiveright and presented by Mrs. H. C. Allnutt to a member of Miss Elkas' class in her absence. M. Cass won the two prizes in the junior class — the Asbestos Corporation Limited scholarship for obtaining highest standing in theory and practice, and *The Canadian Nurse* award. The latter was presented by Mrs. A. Joyal, a graduate of 1904.

On the evening following graduation exercises over 90 guests gathered in Norton Residence. Many of them were former graduates, some of whom had come from a distance to take part in the anniversary events. In addition, former superintendents, members of the medical staff, their wives and others were present. Class pictures, photographs of doctors, nurses and hospital scenes of past years and snapshots were on display to revive memories for the guests. Mr. D. Burroughs, the hospital engineer for 43 years was given a hearty welcome. Mrs. A. Joyal, the school's earliest known graduate, received a warm tribute from the guests just before leaving the party when everyone stood to sing "For She's a Jolly Good Fellow." J. Moffat a graduate of 1958 gave Mrs. Joyal a copy of her class yearbook.

A low bowl of yellow roses and shasta daisies, and purple tapers in silver candle holders were on the table at which Miss G. Norris, educational director, and Miss R.

REPRINTS

The series of articles published in the Journal during 1958 on

SIMPLIFIED PARLIAMENTARY PROCEDURES

has been compiled in booklet form & is now on sale. These booklets may be ordered from the office to The Canadian Nurse Journal, 1522 Sherbrooke Street, West, Montreal, Que. Use this form to order.

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Smith, nursing instructor poured tea. The new graduates in their crisp white and one student in the quaint uniform of the early 1900's mingled with the guests. A number of student nurses assisted in serving the guests.

SASKATCHEWAN

Swift Current

Louise Miner, provincial Department of Public Health, was the guest speaker at the dinner meeting of the chapter last month. In reviewing past activities, the members feel that this has been a busy, profitable year. A croup tent was given to the hospital and $1500 was donated to the hospital board to furnish the main lounge in the new nurses' residence. Engraved scissors were presented to girls starting their training.

As fund-raising projects, chapter members having a drawing each year — this year the prize was a television set. They also staff nursery facilities during Frontier celebrations so that parents can enjoy events and know that their children are in good hands. A Christmas dance has been planned since it usually proves to be very successful financially. As part of the recruitment program, the chapter sponsors a banquet each year for prospective students. This year two nurses attended the annual provincial convention and one person went to the CNA 50th General Meeting as official delegates.

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Inservice Training Director for a modern 310-bed hospital. Personnel policies & salary excellent. Please apply to: Administrator of The Doctors Hospital, 45 Brunswick Ave., Toronto, Ontario.

Night Supervisor (8:00 p.m.-8:00 a.m.) 4 nights weekly for small Tuberculosis Hospital. Write stating age, experience, when available to Director of Nursing, Grace Dart Hospital, 6085 Sherbrooke Street East, Montreal, Que.

Night Supervisor for 74-bed hospital with planned extension. Gross salary schedule $250 — $280 depending on experience & qualifications. Favorable personnel policies & pleasant working conditions in the heart of the Lake of the Woods sports area. Apply Superintendent, General Hospital, Kenora, Ontario.

Assistant Night Supervisor — Head Nurses for Medical & Surgical Wards — **General Duty Nurses** for 450-bed hospital with training school. Excellent personnel policies. Apply to: Director of Nursing, St. Joseph's Hospital, Victoria, British Columbia.

Administrative Supervisor — Pediatric Dept. 30-bed unit in modern hospital; good personnel policies. Apply: Director of Nursing, Civic Hospital, Peterborough, Ontario.

Operating Room Supervisor for 60-bed hospital with expansion program to 80 beds; 51 miles from Ottawa, 65 miles from Kingston. Experience desired. Apply, Superintendent, Great War Memorial Hospital, Perth, Ontario.

Operating Room Supervisor, Night Supervisor, Assistant Head Nurses. Excellent personnel policies. Apply Director, Shriners' Hospital for Crippled Children, 1529 Cedar Ave., Montreal, Quebec.

Superintendent for modern 25-bed hospital. Apply stating qualifications & salary expected, to Mrs. Emery Robertson, Supt., Tobique Valley Hospital, Plaster Rock, New Brunswick.

Assistant Matron with postgraduate preparation for 140-bed hospital with building program in operation. For further particulars, write Matron, King Edward VII Memorial Hospital, Bermuda.

Registered Nurse for 31-bed hospital, commencing salary $210 plus maintenance, 40-hr. wk. Individual room in separate residence. 4-wk. holiday after 1-yr. service. Apply to: Matron, Municipal Hospital, Eckville, Alta.

Registered Nurses for modern hospital, comfortable home. Starting salary $250 per mo., maintenance $35 per mo. Apply: Superintendent, Lorne Memorial Medical Nursing Unit, Swan Lake, Manitoba.

Registered Nurses: for 50-bed Hospital, Obstetrical & General Duty. Rotating shifts, 40-hr. wk. Apply: Director of Nursing, Ajax & Pickering General Hospital, Ajax, Ontario.

Registered Nurses for general duty in all departments — including operating room, premature & newborn nursery. Good salary & personnel policies. Apply: Director of Nursing, Victoria Hospital, London, Ontario.

Registered Nurses for modern 60-bed general hospital 40-mi. south of Montreal. Salary $250 per mo. $5. increase every 6-mo. for 5 increases. Monthly bonus for permanent evening & night shifts. 44-hr. wk. Board & accommodation available in new motel-style nurses' residence. Apply: Supt. Barrie Memorial Hospital, Ormstown, Que.

Registered Nurses or equivalent European training (3) for 30-bed rural General Hospital. Starting salary $160 per mo. full room & board free, Blue Cross paid, 46-hr. wk. 8-hr. general duty, 1-wk. vacation each quarter (1/4), 20-mi. from Ottawa. Skiing, skating, swimming, boating etc. Apply to: Miss Hardy, Matron, Gatineau Memorial Hospital, Wakefield, Que.

Registered Nurses (2) $260 per mo. with increments each yr. 3-wk. vacation & sick leave, residence on grounds. Apply to Secretary, Vanguard Union Hospital, Vanguard, Sask.

Registered Nurses for new, modern 640-bed county hospital. Salary: $338-$392 per mo. Excellent working conditions. Liberal sick leave, vacation, retirement benefits. California registration or eligibility for registration required. Apply, Administrator, Kern General Hospital, Bakersfield, California.

Registered Nurses— Salary $325-$360 in 18 mo. differential on p.m. shift $1.50, nights $1. Openings in Obstetrical & Medical-Surgical areas. Apply to Personnel Dept. Woman's Hospital, 432 E. Hancock Ave., Detroit 1, Michigan.

Registered Nurses: Positions available in all areas & on all shifts. Ultra modern, new 254-bed General Hospital located in the heart of beautiful sunny Castro Valley, just 30 minutes drive from San Francisco. This is a busy residential community which offers casual California living at its very best. Many excellent schools & colleges within easy commuting distance. Progressive personnel policies include free hospital & surgical insurance, paid sick leave, paid vacations, 7 recognized holidays & other benefits. No split shifts; evening & night duty salary differential, also differential paid for operating room, delivery room & nursery service. Uniforms laundered free. Basic salary for general staff duty, $320 per mo. Salaries for other positions commensurate with assignments. Please write: Personnel Manager, Eden Hospital, 20103 Lake Chabot Road, Castro Valley, Calif.

Registered Nurses for 88-bed voluntary non-profit hospital in Community of 11,000. Basic salary $295 per mo. with increments of $5 every 6-mo. up to 2-yr.; 40-hr. wk.; 7 paid holidays; sick leave accumulative to 36-dy. Address inquiries to: Director of Nurses, St. John's Hospital, Red Wing, Minnesota.

Registered Nurses: Spend your winter in the Sunny Southwest — New Mexico, "The land of Enchantment". Vacancies for staff duty in Medicine, Surgery, Obstetrics, Pediatrics, and Operating Room. Salaries $285-$315, days; $10 differential for evenings & nights; $15 differential, operating room. No shift rotation. Excellent job benefits. Board and room in nurses' residence, $43 per month. Free transportation via 1st Class Air travel to Albuquerque and return in exchange for a 1-yr. employment contract. Write or call collect Mrs. Margaret Nelson, Director of Nursing, Presbyterian Hospital Center, 1012 Gold Ave. S.E. Albuquerque, New Mexico. Phone 3-5611.

Registered Nurses & Certified Nursing Assistants for new expanding 88-bed hospital in a pleasant progressive town. **General Duty Registered Nurses** start $220, annual increments to $240, **Certified Nursing Assistants** $150, annual increments to $180. 2-wk. shift rotation, bonus for 4-12 & 12-8 shifts. Accumulated sick leave to 60-dy. Only 1-hr. drive to Toronto, to other cities & resort areas. Local swimming pool, artificial ice arena, bowling, etc. Apply: Director of Nursing, Dufferin Area Hospital, Orangeville, Ontario.

Registered Nurses and trained Nursing Aides needed for a large expanding City Hospital in Edmonton, Alberta. **General Duty** $240 - $270 per mo. plus laundry; **Staff Nurses** $270 - $300 per mo. plus laundry; **Certified Nursing Aides** $168 - $189 per mo. plus laundry. Experience available in all departments including Operating Rooms & Case Rooms. Credit given for postgraduate work & past experience. Opportunities for advancement. Liberal sick leave & vacation allowances. 40-hr. wk. For particulars apply to Director of Nursing, Royal Alexandra Hospital, Edmonton, Alberta.

Registered Nurses for General Staff & Operating Room in modern hospital (opened in 1956). Situated in the Nickel Capital of the world, pop. 50,000. **Salary: $260 per mo. with** semi-annual merit increments, **plus annual bonus plan.** Recognition for experience. Excellent personnel policies. Assistance with transportation can be arranged. Apply Director of Nursing, Memorial Hospital, **Sudbury,** Ontario.

Registered Nurses or Graduate Nurses for General Duty (2) for 16-bed hospital. Salary schedule according to the A.A.R.N. suggested policy. Basic starting for R.N. without experience $240 & if experienced, salary adjusted accordingll, otherwise increment increases every 6-mo. up to 3-yr. Maintenance $30. Blue Cross group, annual leave of 1-mo. etc. Hospital is centrally located between two (2) Lake resorts. Mrs. J. Bergquist R.N. Matron, Bentley Municipal Hospital #43, Bentley, Alta.

Registered or Graduate Nurses for 110-bed municipal hospital situated in the Peace River district of Northern Alberta. Salary $250 gross. $5 per mo. increase each 6-mo. up to 4 increases. 8-hr. shifts-44-hr. wk. 3-wk. vacation with pay after 1-yr. service. Statutory holidays. Accommodation in nurses residence, $30 per mo. Also **Evening & Night Supervisors** wanted. Salary open. Apply to, Sec.-Treas. M. G. Stanton, Grande Prairie Municipal Hospital District #14, Grande Prairie, Alta.

Surgical Registered Nurses, Staff Registered Nurses for 240-bed General Hospital. 40-hr. wk. 15 working days; paid vacation; 7 paid holidays; sick leave. Surgery starting base pay $338 stand by & call back time extra. **Staff R.N.** starting pay $322 monthly; regular pay increases; P.M. & night differential $10. Apply: Yolo General Hospital, P.O. Box 210, Woodland, California.

Registered Nurses & Licensed Practical Nurses (Male & Female) staff positions available on general staff & special departments for 250-bed nonsectarian hospital located on beautiful Allison Island, Miami Beach, Florida. Accommodations for living-in available. Apply: Director of Nursing Service, St. Francis Hospital, Inc., Miami Beach 41, Florida.

Registered Nurses for General Duty immediately, in 19-bed hospital located 95-mi. southwest of Edmonton. Close to three (3) summer resorts this oil town offers many varied entertainments. There is daily bus & train service to other points in the province. Starting wages are $220 per mo. plus maintenance with a $5 increase every 6-mo. For further information please write or phone. The Matron, Rimbey Municipal Hospital, Rimbey, Alta.

Registered Nurses for General Duty. Salary range $235-$265 depending on qualifications. Residence accommodation available. 74-bed general hospital on beautiful Lake of the Woods. Forward enquiries to Superintendent, Kenora General Hospital, Kenora, Ontario.

Registered Nurses (2) & Licensed Practical Nurse (1) for small hospital, basic salary R.N. $250, L.P.N. $160 with adjustments made according to experience. Full maintenance $25 per mo. uniforms laundered free. Apply stating qualifications & references to Miss S. H. Manhard, Matron, Medical Nursing Unit, McCreary, Manitoba.

Registered General Duty Nurses (2) immediately for 76-bed fully modern hospital on C.P.R. main line & Trans-Canada Highway to Calgary & Banff. Gross salary: $240 per mo. Perquisites $30. $5.00 increment every 6 mo. 8-hr. day, 44-hr. wk. 1 mo. annual vacation with pay. Sick leave with pay. Apply to Matron, Brooks Municipal Hospital, Brooks, Alta.

Registered General Duty Nurses. Salary: $230 per mo. 40-hr. wk. Apply Director of Nursing, General Hospital, Cobourg, Ontario.

Registered General Duty Nurses & Certified Nursing Assistants for new 58-bed hospital. Situated in North Western Ontario. Gross Salary $249 per mo. & $184 per mo., subject to increase after 6-mos. with regular annual increases thereafter. $45 per mo. room & board. Rail are refunded after one year. New 21-bed nurses' residence, single rooms. Apply; stating age & when available to Director of Nursing, District General Hospital, Dryden, Ont.

Registered General Duty Nurses (2) for well equipped 40-bed hospital. Starting salary $200 plus full maintenance. 8-hr. duty, 44-hr. wk. with 40-hr. contemplated. Rotating shifts, long week-end following night duty. Apply: Superintendent Saugeen Memorial Hospital, Southampton, Ontario.

Registered General Duty Nurses for 118-bed General Hospital along the shores of Lake Michigan, 25 mi. from Chicago. Salary: $340 for days, $370 for evenings, $360 for nights. 5 day wk. Good personnel policies. Apply Personnel Director, Highland Park Hospital Foundation, 718 Glenview Ave., Highland Park, Ill.

General Duty Registered Nurses for 100-bed general hospital in town of 6000 on the shore of Lake Huron. Good personnel policies, residence accommodation available. Apply: Superintendent, Alexandra Marine & General Hospital, Goderich, Ontario.

General Duty Graduate Nurses (2). Salary $260 per mo. with annual increments of $10 per mo. Room, board & laundry: $40. 28-day vacation after 1-yr. service. All statutory holidays paid. Customary sick leave. Graduate complement, 5. Apply giving full details to Matron, Slocan Community Hospital, New Denver, B.C.

General Duty Nurses one (1) immediately, one (1) in December for 31-bed hospital $235 per mo. less $45 full maintenance $10 increase after 1st. & 2nd. yr. 40-hr. wk. 5-hrs. from Vancouver. Apply Administrator, St. Bartholomew's Anglican Hospital, Lytton, B.C.

General Duty Nurses for modern 35-bed hospital situated on beautiful South Shore. Good personnel policies. Excellent living quarters. Apply Superintendent, Fishermen's Memorial Hospital, Lunenburg, Nova Scotia.

General Duty Nurses for an accredited 64-bed hospital. Starting salary: $235 per mo. with annual increments. Good personnel policies with sick leave benefits, holidays & paid vacation. Residence accommodation available. Apply Director of Nursing, Douglas Memorial Hospital, Fort Erie, Ontario.

McKellar General Hospital, Fort William, Ontario requires **General Duty Staff Nurses** interested in coming to northwestern Ontario. Basic salary, $240 per month. Good personnel policies. Renovation program now complete. Openings in all departments. For further information apply to the Director of Nursing.

General Duty Nurses for modern 42-bed hospital, starting salary, new graduates $245 with two (2) yr. experience $255; these rates to be revised October 1st. Ontario registration required for maximum salary. Annual increments, 6% bonus for evening & night shifts. 44-hr. wk. with 8 statutory holidays, annual vacation 21 days first yr. 28-dy. thereafter, monthly sick time allowance. Good living accommodations available. Apply to: Nursing Supervisor, Sioux Lookout General Hospital, Sioux Lookout, Ontario.

General Duty Nurses for 163-bed Tuberculosis Sanatorium. Good salary & personnel policies. Residence accommodation available. Please apply Director of Nurses, Sudbury & Algoma Sanatorium, P.O. Box 40, Sudbury, Ontario.

General Duty Nurses for 100-bed modern hospital in south western Ontario. Please apply to: Director of Nurses, Tillsonburg District Memorial Hospital, Tillsonburg, Ontario.

General Duty Nurses for small general hospital beginning salary $300 per mo. — $10 differential p.m. & night duty — 36 hr. wk. Living accommodations available. Apply: Sister Superior, St. Ann's Hospital, Juneau, Alaska.

General Duty Nurses (English speaking) for 466-bed hospital. Nurses' residence available. Salary: $315, California registered — $285, Canadian registered. $22.50 differential for 3-11 & 11-7 shifts. Apply Cedars of Lebanon Hospital, 4833 Fountain Ave., Los Angeles, Calif.

General Duty Nurses for 600-bed teaching hospital in central California. Inservice educational program. Salary $337 — $396; 40-hr. wk. 11 holidays yearly, retirement & sick leave plan. Differential of $20 per mo. PM shift; $15 night shift; Write Personnel Director, 732 East Main St. Stockton, California.

General Duty Nurses for 120-bed modern general hospital. Salary open. Located on the beautiful Niagara Frontier. Centrally located in Buffalo, New York, 15-min. from Niagara Falls, 1½-hr. from Toronto. Apply: Buffalo Columbus Hospital, 300 Niagara Street, Buffalo 1, New York.

Attention! General Duty Nurses 400-bed County Hospital located 2 hr. drive from San Francisco, ocean beaches & mountain resorts in modern & progressive city of 35,000. 40-hr. 5-day wk., 3-wk. pd. vacation, 11-pd. holidays, pd. sick leave, retirement plan & social security. Accommodations in Nurses' Home, meals at reasonable rates, uniforms laundered without charge. Starting salary $333 per mo. plus shift & service differentials. Must be eligible for California Registration. Write Director of Nursing, Stanislaus County Hospital, 830 Scenic Drive, Modesto, California.

General Duty Nurses for 50-bed General Hospital located in college town in mountainous portion of Colorado. Salary: $300 per mo. with periodic increases. Fringe benefits include meals, uniform laundry, sick leave & vacation. Registration requires 3-mo. training in psychiatry & pediatrics on a segregated service. Apply Superintendent, Community Hospital, Alamosa, Colorado.

General Duty Nurses & Operating Room Nurses for 434-bed hospital; 40-hr. wk. Statutory holidays. Salary $250-$312. Credit for past experience & postgraduate training. Annual increments; cumulative sick leave; 28 days annual vacation; B.C. registration required. Apply Director of Nursing, Royal Columbian Hospital, New Westminster, B.C.

General Duty Nurses & Certified Nursing Assistants for 86-bed hospital. Living accommodation available. Collingwood is situated on Georgian Bay & is noted as a vacation land in summer with 7-mi. of sand beach, along with great skiing on the Blue Mountains in winter. For further information apply Director of Nursing Services, General & Marine Hospital, Collingwood, Ontario.

Registered General Duty Nurses salary $250-$284; evening duty additional $10. **Licensed Practical Nurses** salary $194-$215. 40-hr. wk. statutory holidays, liberal sick time, pension plan, holiday allowance, accommodation available in Nurses' Residence, uniforms laundered free. Must qualify for Manitoba registration. Apply: Director of Nursing, Winnipeg Municipal Hospitals, Morley Avenue East, Winnipeg 13, Manitoba.

Graduate Nurses for 70-bed General Hospital. Salary $260-$280; 5-day wk., 28 days vacation plus 10 statutory holidays, after 1 yr. Apply: Matron, St. George's Hospital, Alert Bay, British Columbia.

Graduate Nurses for new 140-bed hospital. 1. Charge nurse for Central Supply, to open and organize dept. 2. Head nurse for Pediatric dept. 3. Head nurse for men's Medical and Surgical 24-bed dept. 4. Operating Room nurse (1) 5. General duty nurses. Positions 1 to 4 all to have postgraduate courses or equivalent in experience. Salaries and personnel policies in accordance with R.N.A.B.C. Positions open August to November 1. Apply, Director of Nursing, General Hospital, Chilliwack, B.C.

Graduate Nurses: For new 63-bed hospital, 30 miles from Vancouver in the Fraser Valley. For Salary rates & Personnel policies. Apply: Director of Nursing, Maple Ridge Hospital, Haney, British Columbia.

Graduate Nurses (3) urgently required for 8-bed hospital in southern Saskatchewan. Salary $260-$290 less $35 maintenance, 3-wk. vacation plus statutory holidays, 40 working hr. wk. & bonus after 1-yr. service, travel fare advanced if necessary. Apply to Mrs. D. L. Knops, Sec. Treas. Rockglen Union Hospital, Rockglen, Sask.

Graduate Staff & Operating Room Nurses 225-bed general hospital, near New York City. Salary $290, including benefits; $30 bonus for evening, $25 for night, extra for call duty. Apply: Director of Nursing, St. John's Riverside Hospital, Yonkers, N.Y.

General Staff Nurses for 400-bed Medical & Surgical Sanatorium, fully approved student affiliation & postgraduate program. Full maintenance. Recreational facilities. Vacation with pay. Sick benefits after 1 yr. Blue Cross coverage. Attractive salary; 40-hr. wk. For further particulars apply Supt. of Nurses, Nova Scotia Sanatorium, Kentville, N.S.

General Staff Nurses for 370-bed approved General Hospital with intern & resident program. $315 per mo. starting salary. $15 per mo. merit increases at 12, 24 & 36 mo. 40-hr. wk. 2-wk. paid vacation, paid sick leave, 7 paid holidays. Pleasant coast city in outstanding recreational area. Apply Director of Personnel, Seaside Memorial Hospital, Long Beach 13, California.

Staff Nurses for 250-bed General Hospital, located on the Bay of Quinte; approved School of Nursing; planned In-Service education program; desirable personnel policies. For further information, Apply to: Director of Nursing, General Hospital, Belleville, Ontario.

Staff Nurses 600-bed general & tuberculosis teaching institution in central valley City. Accredited State & Junior Colleges in immediate vicinity, Liberal personnel policies. Salary $320-$360. Full maintenance available. Write — Director of Nursing Service, Fresno County General Hospital, Fresno 2, California.

Staff Nurses for 170-bed hospital; starting salaries $315-$345 per mo. 40-hr. 5-dy. wk. Positions available in Psychiatry, Operating Room & on Medical-Surgical floors. Call & stand-by time is paid O.R. personnel in addition to salary. Paid hospitalization, life insurance, vacation & many other benefits. Write for brochure to Director of Personnel, Mount Sinai Hospital, 8720 Beverly Blvd., Los Angeles 48, California.

Public Health Nurses: required in a generalized program in rural & semi-urban area adjacent to metropolitan Toronto. Excellent working conditions including pension plan, group insurance & transportation arrangements. Write: Dr. R. M. King, York County Health Unit, Newmarket, Ontario.

Staff Nurses for 200-bed general hospital; heart of Los Angeles cultural & educational center. **General Duty:** $320 per mo. minimum-days. $25 dif. for 3-11 & $20 dif. for 11-7. Benefits: Time & ½ over 40-hr. wk. Soc. Sec., State Dis. Ins. 2-wk. vacation end of 1-yr. 3-wk. after 5-yr. 7 paid holidays. 12-dy. sick leave. Uniforms laundered. Nurses' residence $10 per mo. Graduates of accredited schools. California license obtainable immediately. Apply: Mildred Croddy, R.N. Director of Nurses, Santa Fe Coast Lines Hospital, 610 South St. Louis Street, Los Angeles 23, California.

Staff Nurses for 300-bed General Hospital. Attractive personnel policies plus differential for specialties, afternoon & night duty. Opportunities for advanced education. Apply to Director of Nursing Service, Kaiser Foundation Hospital, Oakland 11, California.

Pediatric Nurses for 100-bed Pediatric teaching hospital; air conditioned. Good personnel policies. Base salary-rotation $290 per mo. Evenings or night $304 per mo. Apply: Director of Nursing Service, University of Texas Medical Branch, Galveston, Texas.

Operating Room Nurse (P.M.) for 147-bed General Hospital located in a beautiful residential surburb along the North Shore of Chicago. Modern ranch style nurses' homes with attractively furnished private bedrooms. 40 hr. wk. Salary: $365 for days, $395 for evenings. Other employee benefits. Contact the Personnel Director, Highland Park Hospital Foundation, Highland Park, Illinois.

Public Health Nurse (Qualified). For generalized program in city of 53,000. Starting salaries dependent on experience: minimum, $3250, maximum, $4000. Annual increment, $200. 4-wk. annual vacation. Pension plan, Blue Cross, P.S.I. employer shared. Transportation provided. Apply, Dr. C. C. Stewart, B.A., M.D., D.P.H., Medical Officer of Health, City of Oshawa, Ontario.

Public Health Nurse, qualified, for general program 20-mi. from Toronto. Salary range $3,250 — $4,000. Allowance for experience. 4-wk. vacation; cumulative sick leave; Blue Cross Group Insurance; Pension Plan. Apply: The Director, Ontario County Health Unit (Southern Area), Pickering, Ontario.

Certified Nursing Assistants for immediate vacancies in an accredited 64-bed hospital. Starting salary $180 per mo. annual increments. Good personnel policies with sick leave benefits, holidays & paid vacation. Residence accommodation available. Apply: Director of Nursing, Douglas Memorial Hospital, Fort Erie, Ont.

Chief Dietitian for 140-bed hospital. Training school affiliated with Montreal hospitals. Fare paid. For particulars write Matron, King Edward VII Memorial Hospital, Bermuda.

Plastic Surgery, Jaw Injuries & Burns Centre, St. Lawrence Hospital, Chepstow, Mon. England. (127 Plastic Surgery, 50 Orthopedic Beds). 6-mo. postgraduate course on Plastic Surgery for Canadian trained nurses. Commences April 1st. Post provides opportunity of gaining further experience & seeing something of England. Full national nurses' salary paid. Good knowledge of English essential & must pay own fare to England. This post provides an opportunity for those who wish to take a working holiday with pay. Write quoting two (2) references to T. A. Jones, Group Secretary, 64 Cardiff Road, Newport, Mon. England.

General Staff Nurses (rotating) for 320-bed Tuberculosis Hospital in Canada's Capital. Pleasant living accommodation, liberal personnel policies. For further particulars apply to, Director of Nursing, Royal Ottawa Sanatorium, Ottawa, Ont.

General Duty Nurses for permanent night duty, 8:00 p.m.-8:00 a.m. 4 nights weekly & 2 nurses for day duty 8:00 a.m.-4:00 p.m. Write stating age, experience, when available to Director of Nursing, Grace Dart Hospital, 6085 Sherbrooke Street East, Montreal, Que.

Operating Room, Obstetrical, General Duty Registered Nurses & Nurse Anesthetist to staff remoded General Hospital in Seattle. Room & meals provided plus salary. Contact, Director of Nursing, Riverton General Hospital, 12844 Military Road, Seattle 88, Washington.

Assistant Director of Public Health Nurses required by the City of Regina, to assist in the planning, development, administration & supervision of the City's Public Health Nursing Program. To be successful, applicants should have a valid Public Health Nursing Degree in Public Health Administration. Salary $3,850-$4,914 per annum, commensurate with qualifications. Our present Director of Training is due to retire from service approximately December 25, 1958, & successful applicant for Assistant Director may expect promotion to that position. Applications & enquiries should be directed to Personnel Department, City Hall, Regina, Saskatchewan.

Evening & Night Supervisors (3) for new 100-bed General Hospital opening about January 2nd., 1959. Initial salary $3,480 per annum plus salary credits for postgraduate preparation & experience. Regular increments. Laundry provided. Work week averages 40-hr., straight 8-hr. day. 10 statutory holidays & 20 working days (4-wks) vacation per yr. Experience in obstetrics preferred. Must be eligible for registration in B.C. Hospital situated about 15-mi. from downtown Vancouver. Apply: Miss Ada George, Director of Nurses, Box 190, North Surrey, British Columbia.

Nurses for floor duty in 54-bed General Hospital. 5-dy. wk. with sick leave & vacation. State Nurses Association pay scale. Write or phone McMinnville Hospital, Inc., McMinnville, Oregon.

Night Supervisor (experienced) for 85-bed General Hospital. Experience in casualty & operating room an advantage. Duties to start December 15. Apply: Director of Nursing, The Portage Hospital District #18, Portage la Prairie, Manitoba.

HOSPITAL NURSES REQUIRED FOR
Ste Anne's Veteran's Hospital, Ste Anne de Bellevue, P.Q.
$2,700-$3,150 and $3,120-$3,540

Candidates must be graduates of an approved school of nursing and registered in a Province of Canada. Benefits include 5-dy. wk. 3-wk. vacation, sick leave, excellent pension plan, term insurance & optional hospital-medical coverage.

Residence accommodation available at nominal cost.

***For details, write to* CIVIL SERVICE COMMISSION, OTTAWA. Please quote competition 58-831.**

General Duty Nurses for R. W. Large Memorial Hospital United Church of Canada at Bella Bella 300-mi., north of Vancouver on B.C. Coast. Transportation refunded after 1-yr., Apply to, Matron, R. W. Large Memorial Hospital, Bella Bella, British Columbia.

Supervising Nurse to help plan, equip & operate a new & modern intensive care unit of 21-beds to be opened in the spring of 1959. Position available at once. Salary range between $345 - $410 depending on training & qualifications. Write, wire or call, collect, Director of Nursing, Samuel Merritt Hospital, Oakland, California, OLympic 5-4000.

Registered Nurses (2) for 16-bed modern hospital salary $260 per mo. gross, $5 increments each 6-mo. for 4 increases, 8-hr. day, 44-hr. wk. 3 wk. vacation with pay after 1-yr. service plus statutory holidays, living quarters in hospital. Apply: Secretary or Matron, Wilson Memorial Hospital, Melita, Manitoba.

General Duty Nurses (3) for 64-bed hospital, salary $250 less $35 for room & board, $5 increase after 6-mo. for 6 increases, 44-hr. wk. 4-wk. paid vacation after 1-yr. service. Statutory holidays, 1½-dy. sick leave per mo. Transportation up to $50 refunded after 1-yr. service. Apply: Sister Superior, Providence Hospital, High Prairie, Alberta.

Registered General Duty Nurses (3) for modern 17-bed General Hospital, situated in the coal mining & oil fields, close to U.S.A. & large shopping centers. Salary $260, good policies. For further information please. Apply: Mr. Ivan Antonichuk, Sec. Mgr. Bienfait Coalfields Union Hospital, Bienfait, Saskatchewan.

Registered Nurses for 95-bed hospital, starting salary $150 plus full maintenance. 1-mo. vacation after 1-yr. Increase of $10 yearly up to $180. Apply: Superintendent, Harbour View Hospital, Sydney Mines, Nova Scotia.

Operating Room & General Duty Nurses for expanding active 350-bed General Hospital. 8-hr. day, 5-dy. wk. with 3-wk. vacation for 1st & 2nd year; thereafter, 4-wk. Apply: Director of Nursing, Port Arthur General Hospital, Port Arthur, Ontario.

Registered Nurse (1) Licensed Practical Nurse (1) immediately, for 10-bed hospital, salary R.N. $275 per mo., L.P.N. $190 less $25 per mo. full maintenance, living quarters in hospital. Apply: Birch River Hospital Unit, Birch River, Manitoba.

Registered Nurse for Allergist's Office in Windsor, Ontario. Excellent opportunity for permanent & progressive nursing career. No typing or book-keeping. Comfortable living quarters on premises if required. Reply in writing only, giving age, marital status, experience, date available, etc. Interview will be arranged. To: Dr. Mary Young, 887 Victoria Avenue, Windsor, Ontario.

Registered General Duty Nurses for 120-bed hospital. Salary $235 per month, shift differential, 40-hour week. Apply: Director of Nurses, Plummer Memorial Hospital, Sault Ste. Marie, Ontario.

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WOODSTOCK GENERAL HOSPITAL

FOR HEAD NURSE, MEDICAL FLOOR 3-11

ALSO GENERAL STAFF NURSES

5 DAY WEEK, GOOD PERSONNEL POLICIES

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PUBLIC HEALTH NURSES GRADE (1)

British Columbia Civil Service

Positions available for qualified Public Health Nurses in various centres in B.C.

Salary: $290 rising to $345 per mo., car provided. An opportunity for interesting & challenging professional service in this beautiful & fast developing province. Competition No.: 58:511.

For information & application forms, write

THE DIRECTOR,
PUBLIC HEALTH NURSING, DEPT. OF HEALTH, VICTORIA, B.C. or
THE CHAIRMAN,
B.C. CIVIL SERVICE COMMISSION, 544 MICHIGAN STREET, VICTORIA, B.C.

REGISTERED NURSES — $2,700-$3,540
(According to Qualifications)
CERTIFIED NURSING ASSISTANTS — $2,040-$2,400

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TORONTO

WESTMINSTER HOSPITAL
LONDON

Employees in both hospitals work a 5-dy. wk.
Application forms available at your nearest Civil Service Commission Office, or main Post Office, should be forwarded to the CIVIL SERVICE COMMISSION, 25 ST. CLAIR AVENUE EAST, TORONTO 7, as soon as possible.

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1. CLINICAL SUPERVISORS IN MEDICINE & SURGERY
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WINNIPEG 3, MANITOBA.

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(12 miles west of Toronto)

Hospital opened May 15th, 1958

Head nurse with experience required for medical ward (30-bed unit).

Generous benefits, 40-hour work week.

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Graduate Nurses! Write today to Director, Cook County School of Nursing, Dept. C., 1900 West Polk Street, Chicago 12, Illinois.

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requires

AN ASSISTANT SUPERINTENDENT OF NURSING

for the Hospital for Mental Diseases, Selkirk, Manitoba.

Qualifications: Registered Nurse Preferably with Mental Nursing Certificate.

Duties: To assist the Superintendent of Nursing in the supervision and direction of nursing staff and to assist in the teaching program under the direction of the instructress of Nursing.

Salary Range: $3120 — $4020 per annum, less $300.00 per annum for full maintenance.

The above position offers full Civil Service benefits, liberal sick leave with pay, four weeks' vacation annually with pay and pension privileges.

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School with 45 students — 1 class a year. 5-day 8-hr. week. Personnel Policies excellent. Not necessary to teach science subjects.

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1. Supervisors for Medical Dept. & Operating Room. Salaries according to qualifications.
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For further information apply Superintendent,

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Are invited to enquire re: employment opportunities in a well-staffed new 125-bed hospital in suburban west Toronto. General duty salary range: $240-$290 per mo. Residence accommodation optional. Personnel manual forwarded on request. Enquire to:

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Opportunities for men & women on the service of your choice. A 953-bed teaching hospital with a friendly atmosphere, well planned orientation program, active graduate nurse club, cultural advantages & excellent transportation facilities.

Starting salary: $325 per mo. 6 holidays, sick leave, 3 wk. vacation.

For further details write:

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Enjoy Western Canada's climate & hospitality

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requires

GENERAL STAFF NURSES

1,500-bed teaching hospital, heart of British Columbia's Medical centre — new 500-bed addition opening 1959. Attractive personnel policies. Salary: $260-$300 per mo. Eligibility for registration in B.C. necessary.

Please apply to:

Personnel Department
Vancouver General Hospital,
Vancouver 9, British Columbia.

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Positions available on nursing staff — salaries in line with those of other public health organizations. Good personnel policies. Knowledge of French language not essential.

Apply: District Director

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For the Municipal Nursing Service & for Staff positions in Health Units.

Salary range — $3,000 - $4,140 per annum, depending on qualifications & experience.

Excellent holiday, sick leave & pension programs.

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DEPT. OF PUBLIC HEALTH,
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WORLD HEALTH ORGANIZATION REQUIRES A NURSE EDUCATOR TO TEACH WARD ADMINISTRATION AND CLINICAL TEACHING IN SINGAPORE

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Applications should be made in writing, to:

PERSONNEL OFFICER
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GENEVA, SWITZERLAND.

Envelopes should be marked NURAD. Only candidates seriously considered for appointment will receive replies.

CENTRAL SUPPLY ROOM SUPERVISOR

required in January

Previous experience in central supply
Operating Room work or as Head Nurse is essential
Interesting position for the right person
Our present C.S.R. Supervisor is retiring at the end of the year
Good salary and personnel policies

For further information apply to:

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UNIVERSITY HOSPITAL

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Requires

General Staff Nurses for Medical, Surgical, Obstetrical and Pediatric Services. Forty hour week. Salary $250 to $290 gross per month. Differential for evening and night duty. Residence accommodation if desired.

Apply to:

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TWO (2) REGISTERED NURSES

For a new modern, 46-bed hospital. — Salary $255 - $285 per month.

40-hour week, no split shifts, sick leave,
3 weeks vacation plus 8 statutory holidays, full maintenance.
Meals, living accommodation in Nurses' Residence,
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Apply:

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GENERAL DUTY NURSES

(for all departments)

Gross salary: $235 per mo. if registered in Ontario. $215 per mo. until registration has been established. $20 per mo. bonus for evening & $10 for night duty. Annual increment of $10 per mo. for 3 years.

44-hr. wk., 8 statutory holidays, 21 days vacation.

12 days leave for illness with pay after 1 yr. of employment.

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Graduate Nurses wanted for All Departments

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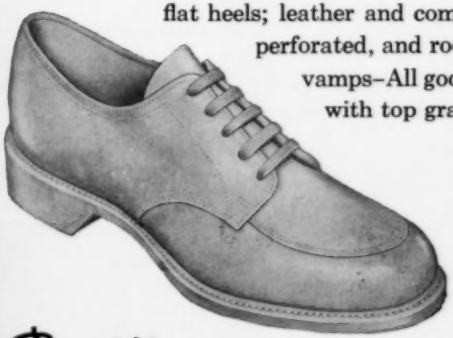

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